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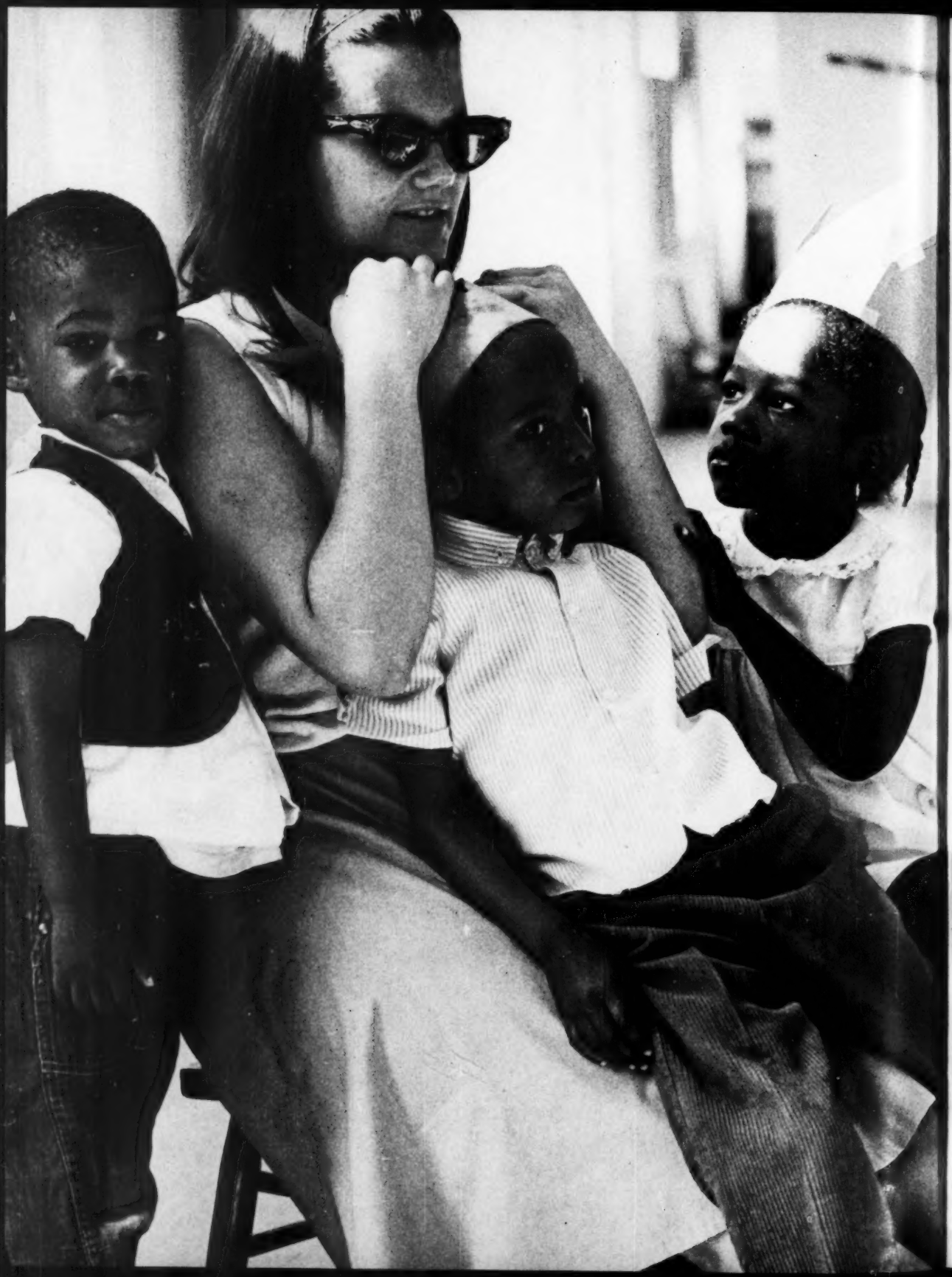

VOLUME 13 • NUMBER 4 • JULY–AUGUST 1966

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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A warm adult-child relationship, as exhibited by this young aide and her three charges in a center for preschool children, may be one key to opening up a child's interest in learning. To provide this and other stimulants to intellectual growth, many "preschool enrichment" experiments are being conducted today. Something of what is known thus far about their effects is described on pages 130 to 134.

children

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some early findings of research on . . .

One of the most salient recent educational movements in this country is the widespread development of compensatory programs for culturally deprived children, especially at the preschool level. Project Head Start, sponsored by the Office of Economic Opportunity, alone reached well over half a million children in its first year of operation, and thousands of preschool children are enrolled in other programs for the disadvantaged. Although designed primarily to serve educational ends, the value of these programs goes beyond education in any narrow sense. Based on premises about the potential effectiveness of early compensatory intervention as a means of breaking intergenerational cycles of economic and cultural deprivation, the effects of preschool enrichment programs promise to have important meaning for child-care programs generally. Given their recency and their proliferation, exhaustive treatment of the subject now would be premature; but a preliminary examination of some of the preschool programs and early findings of research concerning their effects is not untimely.

A basic consideration in the development of compensatory educational programs is the observation, by no means recent, that children from poverty-ridden homes tend to do poorly in school. They come to school less well prepared than middle-class children and fall further behind each year. The main effect most often expected from preschool enrichment programs is a change in this tendency, that is, the child's involvement in such a program becomes a means of improving his readiness for school and, in turn, his academic achievement.

The focus on this end does not preclude concern about and provision for other types of outcome; however, the early findings pertain almost exclusively to educational effects. Before examining these find-

CLAY V. BRITTAIN

PRESCHOOL PROGRAMS FOR CULTURALLY DEPRIVED CHILDREN

ings, let me mention the rationale underlying the programs and the followup studies which evaluate them.

These programs are shaped largely by assumptions about the characteristics of "culturally deprived" children which underlie their inferior academic performance. These characteristics, which follow patterns of both cognitive and affective deficit—at least from the middle-class point of view—include poor language facility, constriction in dealing with symbolic and abstract ideas, narrowness of outlook because of the narrowness of the familiar environment, passivity and lack of curiosity, low self-esteem, and lack of motivation for achievement.

In developing enrichment programs, the longer range goal of improving academic achievement becomes the proximal goal of modifying these features in the psychological makeup of the "culturally deprived" child; thus, plans for systematic evaluation include both the long-range assessment of school achievement and the assessment of more immediate psychological changes, typically as they are reflected in test scores. Early findings are mainly of the latter type, though this is not exclusively the case.

Early results

Although the preliminary findings concerning the effects of preschool enrichment programs are predominantly positive, this is not universally so. Gains in IQ scores and augmented language-cognitive ability have been found in several followup studies, along with indirect evidence of greater interest in school and motivation for doing schoolwork. But this is not evenly true; some followup studies have not found such effects. I will here examine both types of findings.

Two of the earliest programs are the Peabody Early Training Project [1] near Nashville and the program of the Institute for Developmental Studies [2] directed by Martin Deutsch in New York City. Although the directors of both projects emphasize the importance of long-range followup studies to determine program effectiveness, preliminary results have been reported. From the Peabody project, Gray and Klaus [1] report substantial increase in IQ scores, as measured by either the Stanford-Binet or the Wechsler Intelligence Scale for Children (WISC), among children in the program as compared with those of children in control groups. There were gains of 5 and 6 points in two treatment groups and losses of 4 and 6 points in two control groups. Children in treatment groups also had higher scores on the Peabody Picture Vocabulary Test and the Illinois Test of Psycholinguistic Ability, and when they entered the first grade they performed better on reading readiness tests. From the Institute for Development Studies, Goldstein [2] reports comparable differences in Stanford-Binet IQ scores between children attending the experimental preschool program and controls. As in the Peabody project, there were apparently control group losses as well as experimental group gains. Also, as before, the experimental group performed better on the Peabody Picture Vocabulary Test. In both programs, gains in the early experimental groups had been maintained for about 2 years.

From an experimental nursery school program in Philadelphia, Beller [3] reports similar findings. The children gained about 6 points in Stanford-Binet IQ scores from mid-year in the nursery school to mid-year in kindergarten. Also, at the time of testing in kindergarten, the nursery groups were on the average about 8 points higher in IQ scores than control children with no nursery school experience.

The nursery groups performed better than the control groups on the Peabody Picture Vocabulary Test. A group verbal intelligence test (Philadelphia Verbal Abilities) also reflected the effects of nursery school, but results of an individual nonverbal test (Goodenough Draw-a-Man) showed no consistent difference between the nursery and control groups.

In addition to test scores such as these, there are other indications of the effectiveness of preschool enrichment programs. Weikart, Kamii, and Radin [4] report from a study in Ypsilanti, Mich., that children who had been in the preschool program had better kindergarten attendance records than the control group children. They were also rated higher by their kindergarten teachers on interest in subject matter, initiative, verbal communication, imagination, and possessiveness toward the teacher.

In the Philadelphia study,[3] the nursery school children were rated as more casual, expressive, and flexible than the control group children in reaction to test and learning situations in kindergarten.

Less systematic but interesting impressions were reported in the other preliminary studies I have mentioned. Goldstein [2] cites statements from parents concerning the positive effects on other children in the family of the child's involvement in the enrichment program of the Institute for Developmental Studies. And Gray and Klaus [1] report indications of effects of their early training project on culturally deprived children not enrolled in it.

There are, in addition, many instances of impressionistic judgment of the good effects of small enrichment programs for which systematic followup is not feasible. Such impressions seem to be universally favorable, in most instances highly so.

But there is another and more cautionary side to the picture. Although there are few studies with negative findings, the results of these studies are too important to be ignored. The most unequivocally negative findings to date, it seems to me, are reported by Alpern [5] from a program in Indianapolis, Ind. He reports that 5-year-old children who attended a preschool program for 7 months made substantial gains on the Metropolitan Readiness Test, but so did children in the control group. In both groups, gains were statistically significant, but group differences were not. Both made slight and nonsignificant gains in Stanford-Binet IQ scores. On the bases of these findings, he is strongly skeptical about the value of short-range preschool programs. A followup study 17 months later showed no difference between experimental and control subjects in first grade scores on the Metropolitan Readiness Test or in ratings by teachers of academic motivation and progress.

Maintenance of gains

But even when good effects of preschool programs are evident in gains in test scores and observable behavioral changes, are they maintained over extended periods of time? This is a crucial question which can be answered only by long-range followup studies. However, the findings reported by Weikart and others [4] from the Ypsilanti study are especially significant. At the time of the followup study, three small groups of children had been admitted to the prekindergarten program. These groups, together with control groups, were called "waves." Children in wave 0 entered in the fall of 1962 as 4-year-olds and had, at the time of reporting, spent 1 year in the experimental nursery and 1 year in kindergarten. Wave 1 entered in 1962 as 3-year-olds and had spent 2 years in the nursery. Wave 2 children entered in 1963 as 3-year-olds and had spent 1 year in the nursery.

Scores on the Peabody Picture Vocabulary Test, the Illinois Test of Psycholinguistic Ability, the Gates Reading Readiness Test, and the Stanford-Binet Intelligence Scale all provided indications of the effects of attending nursery school, but the findings of interest pertain to Stanford-Binet IQ score changes. In all three waves, the experimental and control groups diverged during their first year in the program and at the end of the year group differences were impressive. But for waves 0 and 1, this trend was reversed during the second year. At the end of the second year, the group differences were no longer statistically significant.

Similar findings have been reported by Larson and Olson [6] from a program in Racine, Wis. At the end of a year in a well-designed kindergarten program, the experimental group performed substan-

Clay V. Brittain has been with the Children's Bureau's division of research as a child welfare research analyst for the past 2 years. Previously, he was assistant professor of education, teaching educational psychology and educational research, at Emory University, Atlanta, Ga. His Ph. D. in human development is from the University of Chicago.

tially better than a comparison group in scores on the Illinois Test of Psycholinguistic Ability. But by the end of the first grade this and other signs of superiority in the children in the experimental group over the children in the control group were no longer evident.

Preliminary findings, however, are not consistent on the extent to which gains from these preschool programs are maintained. As noted above, gains in IQ scores that had already persisted for 2 years were reported from the Peabody project and the Institute for Developmental Studies.

Precisely how we should interpret these initial results is not clear. The extent to which they are regarded optimistically probably would vary from one reader to another. But it seems neither rash nor unduly pessimistic to suppose that the variability they reflect will continue to be evident, even in less preliminary findings. Imperfections in assessment methods would of course be enough to assure variability. But programs of early enrichment differ from one another so extensively they almost assure different results.

Program differences

Getzels [7] has described these program differences in terms of the different underlying assumptions which the programs reflect about the deficiences of the culturally deprived child. Present preschool programs for culturally deprived children, he suggests, may fall into these three broad categories:

1. Programs based on the assumption that differences between the culturally deprived child and the middle-class child are matters of degree rather than of kind. Hence, if a given type of nursery program is good for the middle-class child, it is also good for the culturally deprived child. The aim in these programs is to provide supplementary experience.

2. Programs based on the assumption that what culturally deprived children mainly lack is familiarity with school-related objects and activities. The aim here is to provide academic-preparatory preschool experience.

3. Programs based on the assumption that the culturally deprived child differs fundamentally from the middle-class child in self-concept, language, values, and perceptual processes. The aim here is to provide compensatory experience sufficient to modify these environmental effects.

The wonders of the printed page are introduced to two of the children of a Project Head Start preschool center.

As results accumulate, findings should be analyzed in relation to some such typology of programs as Getzels describes. But there are also more simple program differences on which results should probably be examined. They include ages of children at entrance, program duration and amount of time children spend in it, staff characteristics, and the nature and amount of parental involvement in the program.

The interprogram variation in initial ages of the children spans a difference of about 2 years, and the entrance age varies from 3 years in some programs to 5 years in others, but modally the entrance age seems to be 4. In view of what is almost the *raison d'etre* of the preschool programs—that is, early intervention is crucial—an examination of results in relation to age differences should be significant.

The programs vary in length from a few weeks or months to several years. They also vary in the amount of time the child spends in the program: from sessions of 2½ or 3 hours a week to sessions of 5 hours for 4 or 5 days a week. Economics indicate the desirability of examining possible relationships between time dimensions and program results.

Two types of program variations in terms of staff characteristics have a bearing: differences in professional training and experience and differences in personal characteristics. With respect to the first, there are several staffing patterns. For example, some programs use both professional and nonprofessional teachers; others use only experienced and certified teachers. Comparative data reported by Beller [3] are significant here. In one program, all teachers had at least 1 year of experience in teaching culturally deprived children; in two others the staff included

inexperienced teachers. Differences favoring the experimental group were more clearly evident in the first program.

The second type of variation in staffing is represented by the Peabody Early Training Project.[1] All of the children in this program are Negro. In the assignment of staff members, attention was given to balanced representation in sex and color to provide the children with appropriate role models. The consequences for achievement motivation should be particularly significant.

Minimal level of parental involvement is no doubt essential for the success of any program, but there are at least three types of interprogram variation in parental role. Programs differ in (1) the degree of parental commitment prerequisite to the child's enrollment in the program, (2) the level of parental involvement in the educational processes of the program, and (3) the means of enlisting and encouraging parental involvement. It might be valuable to look at these in terms of different effects on the parents as well as on the children. But more than this, such program differences probably make a difference in the types of children served and in attrition rates, both of which are highly important in interpreting different results.

Focus and goals

Careful analyses of programs would undoubtedly reveal other, and perhaps more significant, differences. But whatever the program differences in terms of which results are analyzed, it seems highly important that the ends desired not be narrowly conceived. In this connection, the focus on school readiness and the improvement of academic achievement is not necessarily at the expense of concern about and provision for other types of outcome. In several instances, followup plans call for the assessment of the effect of the program on the child's development in its multiple dimensions. In the Baltimore Early School Admissions Project,[8] for example, research studies will assess such health and physiological effects as changes in height, weight, and dental and bone development. It will also assess the effect of the program on the child's emotional development and interpersonal behavior. This broad assessment will increase the relevance of the findings for child-care programs generally.

But even in terms of educational effects per se, it is important that criteria of desirability not be narrowly construed. Findings reported by Kitano[9] may illustrate a crucial issue here. In his study, he found that children who had been enrolled in a child-care center housed in a public school were rated by their teachers in the early elementary grades as less well adjusted to school than control children not enrolled in such a program. He suggests that this difference may have been due to the assertiveness and spontaneity nurtured in the permissive atmosphere of the child-care center but not regarded as appropriate in the more highly regimented elementary school classrooms.

This possibility points up the importance of the questions raised in Getzels' paper[7]: "Can the standards of today's school be taken safely as the model for the transformation of the culturally deprived child? Is this what we want for our children, or should some thought be given as well . . . to the transformation of the school itself?"

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a demonstration project corrects its preconceptions through . . .

SOME EFFORTS TO IMPROVE PRIVATE FAMILY DAY CARE

ALICE H. COLLINS

Two years ago the Children's Bureau gave a grant to Friendly House, a community center in Portland, Oreg., to try to develop a new kind of service to improve the quality of day care of children provided directly by one family to another. Called the Day Care Exchange Project, the 3-year project, which is now under the sponsorship of the Portland Community Council, has concentrated on studies of arrangements for family day care already existing in the northwest section of the city and on experimenting with ways of steering families needing day-care services to families likely to provide good child care. Thus far the project has not produced any answers to the important question of how communities can best develop family day care as part of a spectrum of services to children. However, it has modified some preconceptions and raised some new, related questions which may interest others concerned with child welfare.

Northwest Portland is an area where family incomes range from $1,000 a year to over $25,000. While chiefly residential, the area includes sections which are becoming industrialized. It contains several hospitals and a mail order house, chiefly employing women.

In 1962, the Portland Community Council sponsored a day-care workshop which underscored the need for increased day-care facilities by families of both middle and low economic levels and the importance of obtaining information on what was now provided as a basis for planning additional services. The need was especially felt at Friendly House, which was not only receiving increasing requests from working and would-be working mothers for help in finding "babysitters," but was also receiving many inquiries about the possibilities of providing day care from women who wanted to care for other people's children but who did not know how to go about finding the children or whether their homes and child-caring skills were up to the job. Recognizing that a good deal of family day care was already being given, some of it excellent and some not, Friendly House undertook a brief survey of working mothers in northwest Portland, the area it served. It found that many mothers were in need of reliable day-care arrangements and preferred to have them in their own neighborhoods.

Friendly House then drew up a proposal for a project to provide a day-care exchange service to bring together working mothers and day-care mothers who had been selected through a certification program. Under the proposal a small staff of social workers would certify families found suitable to provide day care, conduct an educational program about the service in the community, and provide counseling to parents making use of the exchange. With funds secured from the Children's Bureau, the project got under way on February 1, 1964.

Under the plan, the first year of the project was to be spent on surveying existing private family day-care arrangements in northwest Portland; the next year, on developing a day-care exchange; and the last, on expanding the exchange, if it by then appeared that such a service could improve the quality of family day care for a large number of families at little expense, in terms either of money or of professional time.

Little was known about the families which were already providing day care. The impressions of what they were like ranged from one extreme (the

drunken neglectful neighbor) to another (the wonderful older woman who had been caring for other people's children for many years). In between we envisaged the young mother who cared for her neighbor's child along with her own children—a type we believed would be interested in becoming certified for day care by the projected exchange.

Knowledge about the people who provided family day care, we felt, might provide a basis for setting up standards for certification, since most existing family day-care standards were more concerned with the physical aspects of care than with the elusive characteristics which are sometimes subsumed under the word "warmth." Clues to ways of predicting the quality of care a person could provide without the investment of many hours of casework time would be of value not only for the project, but also for efforts to promote licensing of day-care families.

Moreover, since we saw the future exchange as a service which day-care mothers would join voluntarily, we felt its ability to be helpful to them would depend on an understanding of how they saw their own needs.

The project defines family day care as child care given for more than 10 hours a week in the home of a person unrelated to the child, the child being under 14 and living with his own family. Thus the care might be given at any time within the day's 24 hours. The person giving it we call the day-care mother. However, while "day-care mother" is a useful term for the project, it is not well understood in the community where the familiar "babysitter" is used. We use the terms "natural mother" and "day-care child" for the two other members of what we call "the day-care triangle."

The first survey

Having prepared a list of women known to be giving day care, we proceeded with the survey, which was carried out by experienced social work interviewers. A schedule was designed to yield demographic data and sufficient information about day-care practices in relation to safety, health protection, and child rearing to permit a judgment about quality of care. We also sought information about the attitudes of the day-care mothers toward day care.

The interviewers relied on free discussion, filling out the schedules on their return to the office. Up to three interviews per day-care mother were permitted. Information was thus obtained on a total of 27 day-care mothers.

Alice H. Collins, director of the Day Care Exchange Project in Portland, Oreg., which she describes here, came to the project in May 1964 as a staff social worker. Before that she was for 5 years on the staff of the Portland Community Council. She has also taught at the Portland Continuation Center and at the Portland State College School of Social Work. From 1954 to 1959 she was deputy commissioner of the Division of Youth Service in Boston, Mass.

We assumed that the quality of day care is high in family homes where—

1. The day-care mother is able to perceive the child as a person having particular social, emotional, and physical needs and capabilities which are related to his level of development and the interaction between himself and his culture.

2. The day-care mother is able to respond to, and meet, the needs of the child.

3. The day-care mother and the natural mother collaborate on behalf of the child in a relationship which is more like a friendship than a strictly business relationship.

We can here give only a brief summary of some of the significant findings of our first survey.

Child care was given at all hours of the day and for most of the night, although most of the care provided was for the working day and for 40 to 60 hours a week. Most of the children cared for were of preschool age.

The age range of the day-care mothers was between 20 and 75; a third were under 36. Eighteen had finished high school and nine had had some college education. Nine were in families with incomes below $3,000 a year; nine, between $3,000 and $5,000; and nine, over $5,000. For three, day care was the family's only source of earned income.

Nearly half the day-care mothers said they had begun to give day care casually—as a favor to a friend or acquaintance. The rest—composed largely of younger mothers—gave financial reasons for beginning the service.

Contrary to our expectations, the majority of the day-care mothers had been giving care off and on for at least 5 years, planned to continue, and had fewer children in care than they wanted to have. But two-thirds had not been giving care continuously since they first began. (Similar evidence of under-

use of existing resources in an area of unmet need was found in a study conducted by the Child Welfare League of America.[1])

In the schedule, we had included questions about the natural families of the children in day care, to accomplish two purposes: (1) to learn some facts about these mothers; and (2) to learn whether the day-care mothers had sufficient contact with the natural mothers to know something about the children's family life. We learned that—

- About three-fourths of the natural mothers were employed in "white-collar" jobs, and the rest in "blue-collar" jobs. Nearly three-fourths of the natural mothers were married; the rest were divorced.
- Twenty-six percent of the natural mothers lived within the same block as the day-care mothers, 59 percent lived within 8 blocks of the day-care mother, and 75 percent lived within 1 mile.

Quality of care

Since one of our major objectives was to learn what factors related to quality of care, we developed a set of 13 dimensions for measuring quality. Then two of the social work interviewers independently used seven of these dimensions to rank the day-care mothers according to the quality of their care. They arrived at similar results. The day-care mothers were then classified into three numerically equal groups in relation to quality of care: high; medium; and low. Cross tabulations were made with the other data. One of the most significant findings was that all of the day-care mothers who ranked highest in quality of care had intact families of their own, with children of school age, and were above the poverty level economically.

The interviews offered much less opportunity than had been expected for observing the interaction between the day-care mother and day-care child, chiefly because the day-care mothers had arranged the appointments for a time when the children would be asleep or for other reasons were not present at the interview. However, the interviews produced much other useful information.

For example, nearly all the women initially denied being day-care mothers. Some of this denial, but far from all, could have been attributed to the unfamiliar term. Some day-care mothers "forgot" about the children they were caring for, "remembering" them only toward the end of the interview or even later on meeting the interviewer on the street or at Friendly House. On the other hand, the day-care mothers were more than willing to talk about day care as a service and readily responded to the interviewer's explanation of need for their help in understanding what was being provided. Eventually, they talked very freely; some even told about breaking the law. One woman said she was caring for 13 infants and thus knowingly violating the group-care licensing law; two women who were recipients of public assistance said they had never reported their day-care earnings.

One of the most troubling findings suggested by these interviews was the high degree of discontinuity in care to which children were being subjected. Children, it became evident, were being moved from one day-care mother to another, to relative's care at home, to another day-care mother, to part-time care by older brothers or sisters, to caring for themselves, and round again.

The case interviews generally gave the impression that the relationship between the day-care mother and the natural mother might be of crucial importance both to the quality and the continuity of care the children received. While few day-care mothers reported actual incidents of difficulty with a child's own mother, many gave evidence of having a great deal of emotional investment in the relationship, either negative or positive. Some, after saying everything was "fine" now, talked feelingly about mothers of children they had cared for in the past.

Some surprises

Because we had planned to use small group discussions, lectures, and television programs as methods for improving the quality of existing family day care in the program of the projected exchange, we decided at the beginning of the project's second phase to try these methods out with the day-care mothers we had surveyed.

We were dismayed to find that, in spite of excellent leadership, the provision of coffee and cookies, and the use of every available publicity resource, the discussion groups drew an average of only five persons at each meeting. Those who attended were, with one exception, members of the Friendly House Mothers' Club which had been in existence for 4 years. They included women from each of the quality-of-care ranking groups.

Although discussion was free in all the meetings, the statements about day care were chiefly concerned with the importance of safety, knowing addresses and

telephone numbers of the natural mothers, and "giving security" to children. The women tended to talk interchangeably as day-care mothers and natural mothers since they were both.

In studying the possibility of preparing television programs on family day care, we had another experience contrary to our expectations. A leading television producer in the community was ready to develop some programs with us, but we found we knew so little about the "pressure points" in the day-care mothers' task, the daily routines, and the interaction of the members of the day-care triangle that we did not have enough fresh, meaningful material on which to base a series of educational TV programs. Reluctantly, we postponed the development of the series until we should have a better idea of the audience to be reached and the messages that ought to be conveyed.

At the end of the first 14 months of the project, we were face to face with some unsettling findings. First of all, it appeared that the day-care mothers who ranked highest on quality of care—the type we wanted to attract to the exchange—had children of their own and would be unlikely to participate in group discussions that would take them away from home. It seemed likely, too, that their concern for their own children meant that they would provide day care for other children only when nothing at home made it difficult. The day-care mother's own family difficulties were revealed as one possible source of discontinuity in the day care of children which an exchange could not alter.

Moreover, it seemed unlikely that a central exchange could meet the demands of emergencies—illness, job and hour changes, presence or absence of relatives in both the day-care and natural family—which would require a constantly changing roster of day-care mothers certified for care. Nor could we think of anything we could offer that would induce "good" day-care mothers to join the exchange. We could not assure the best day-care mothers a higher fee as an inducement toward becoming certified members of the exchange since financial supplementation was not part of our plan.

Yet another aspect of the exchange, as originally conceived, began to trouble us. The least adequate day-care mothers had appeared to the social work interviewers to be those who needed to care for other people's children because of deep personal deprivation, either emotional or financial, and so were the most likely to wish to join and use an exchange. However, such day-care mothers would not be able to qualify for certification without a long period of individual help. The exchange could not offer such help without taking on a much larger professional staff than had been planned.

We conjectured that exclusion from a day-care exchange would no more interfere with the provision of day care by inadequate day-care mothers than existing agency regulations were preventing it. We also feared that exclusion might be regarded as only another rejection by women whose inadequacies stemmed from their own past deprivations and so might alienate them from Friendly House, thus cutting them off from badly needed help.

Still another facet of our experience made us question the value of organizing the exchange as originally conceived. This was our observation that day-care triangles were constantly forming, dissolving, and reforming without outside intervention. The calls that came to us were usually for help in an emergency when a grandmother or customary day-care mother was unable to care for a child and the natural mother had to go to work "right away." On such occasions, we phoned one or two of the high ranking day-care mothers in our study sample. Often the woman we phoned offered to find a friend to care for the child and did so, thus reinforcing our belief that a day-care system was already in operation in the community.

However, we felt more strongly than ever that an exchange was needed: to provide for the emer-

A family day-care mother in Portland greets a child as she arrives with her mother, along with some spare clothes.

gencies and changes in day-care arrangements; to permit continuing observation of the quality of the care children were getting; to advise women who were considering going to work about the kind of care available; to develop and maintain opportunities for good family day care to cover a variety of needs—before and after school, evenings and all night, the hours between parental work shifts, or substitute day care for a child who is sick and so unwelcome in his usual day-care home. We believed a day-care exchange could be of service to both the givers and receivers of family day care because of the endlessly changing circumstances which affect the day-care supply and demand—seasonal work, the effort toward home ownership, the need and desire for more education for family members, changing work hours, pregnancy, divorce.

The new exchange plan

Clinical evidence has underscored the importance of continuity of environment for children who are separated from their mothers. Knowing this, we felt that being cared for within the immediate neighborhood of his own home, where there is continuity of surroundings and playmates and probably also of child-rearing practices, might compensate a child in part for whatever discontinuity in caretakers he was subjected too. It seemed to us that a family day-care exchange would work best if it were decentralized into the neighborhoods and social workers in a central office acted as consultants to neighborhood exchange agents. We believe we could identify persons with potential for being such agents, or Day-Care Neighbors among the women in our surveyed population. The prototype would be the woman in a large, extended family to whom the others turned in times of stress or to "just talk."

We therefore modified the plan for the exchange accordingly, but before establishing the neighborhood service we undertook some further studies.

We wanted to learn more about how much discontinuity there was in day care and under what conditions it occurred. We wanted, too, to learn more about the complexity and importance of the relationship between the day-care mother and the natural mother and its connection with continuity of care. We believed that if we were to help the new Day-Care Neighbors bring about improvement in the quality of the interaction between the members of the day-care triangle, we needed to know as much as we could about this interaction ourselves.

Therefore, in the summer of 1965, we undertook a second survey of our original study population, drawing on the project's experience for a baseline for questions about quantity and continuity of care. Only 22 of the original 27 day-care mothers were reinterviewed, as 5 were no longer available for interviews. The participants readily received the interviewers and often amazed them by recalling almost verbatim what they had said the year before, a consequence of casework interviewing in the first survey predicted by our consultant, Christophe M. Heinicke.

In regard to continuity of care, the second survey showed that during the year:

- Twenty of the day-care mothers had cared for a total of 114 children of 79 natural mothers; and of these, 6 had cared for some of the same children as in the previous year, 6 had cared for only 1 child, 5 had cared for 10 or more children. Two of the former day-care mothers had not given any care and did not expect to do so in the future.

- Of the 114 children who received care, almost half had been in the same day-care home less than 6 months; 15 percent had been in the same day-care home for less than 1 month. The children who had been in the respondents' care for the shortest time had been in other nonrelative day care previously. Those who had been in the respondents' care for more than 1 year had previously been cared for at home by their mothers.

In regard to relationships within the day-care triangle, the new study indicated that:

- The natural mothers of the children in care for the shortest time did not maintain contact with the day-care mother after the day care was terminated, nor did the children. The natural mothers of the children in continuous care for more than a year maintained a friendly relationship with the day-care mother afterward, as did the children.

- The children in care for the shortest periods of time were children who required care for more than 50 hours a week because their mothers had to support themselves.

- The termination of the day-care relationship had been instigated by the natural mothers four times as often as by the day-care mothers. The relationship between the day-care mother and natural mother was businesslike where care was shortest and more friendly where care was longest.

Among other studies undertaken was a utilization study through which we attempted to compare the continuity of care and characteristics of the natural mothers in our surveyed population with the same factors in the clientele of three day nurseries and one social agency conducted family day-care service. There seemed to be little difference between users of the two types of services, but the data were not sufficiently comparable to permit satisfactory conclusions.

Since our projected Day-Care Neighbor Service was planned to function in neighborhoods of differing socioeconomic and demographic characteristics and to make use of "neighborliness" (whose very existence has been questioned in some social science literature), we wanted to learn something about possible differences in attitudes and practices that might exist in different neighborhoods. Therefore we carried out a small survey, with a short schedule of questions, of 25 contiguous households in each of 4 different census tracts having different characteristics, particularly in proportions of married women with children, older women, working women, and age of children. Experience had taught us to avoid the use of the word "day care" and of questions which could be interpreted as soliciting people to provide care, so we asked about child-care practices in general, about "neighbors," and about attitudes toward working women.

Over the years, one of the frustrating features of the day-care field has been the lack of interest in day care by the public at large as well as by professional social workers. The neighborhood study gave evidence of this. In general, the respondents, regardless of the neighborhood they lived in, said that they knew very little about babysitting, and then contradicted this statement by adding that people did not formerly use babysitters as much as they do now and then describing their own babysitting customs.

More than 90 percent of all those questioned said mothers should not work unless they "have to." Most of the respondents in three of the census tracts said they thought that the women in their neighborhoods who worked did so because they had to. But about two-fifths of the respondents in the census tract of the lowest socioeconomic level said they thought the women in their neighborhoods worked to earn "extras" because they were bored.

In the census tract of the lowest socioeconomic level, four-fifths of the respondents said they believed that "neighbors don't know each other as well as they used to," but only half of the respondents in the highest socioeconomic neighborhood believed this. Twice as many of those in the highest socioeconomic neighborhood as those in the lowest knew what their neighbors did for a living and twice as many in the former group had visited in their neighbors' homes in the past 3 months. Most of the respondents in the highest socioeconomic area said that if they needed a babysitter, they would find one through their neighbors; in contrast, the respondents in the lowest socioeconomic area said they would seek one through the newspaper or an agency.

Day-Care Neighbor Service

After a 4-month pilot program with two Day-Care Neighbors who helped us plan and organize the projected service, we officially opened the Day-Care Neighbor Service on February 1, 1966. The service's objectives are: (1) to increase the amount of good private family day care for children; (2) to provide information about the operation of the existing day-care system; (3) to develop social work methods and adapt existing methods to reach these goals.

While it is obviously too soon to report on the service, we know that women who themselves provide good day care can be recruited to serve as Day-Care Neighbors for we already have the full complement of six provided for in our budget. Although these women have a variety of socioeconomic backgrounds, each has agreed to our fee of $25 a month. We do not see their role as being "semiprofessional," but rather as making the most of their existing positions in the neighborhood and in the day-care system.

Our experience with the pilot project has led us to believe that, with social work consultation, these Day-Care Neighbors can function effectively in the day-care system. There is no doubt that they can greatly increase our understanding of the operation of that complicated system. At present, this appears to include even a greater degree of discontinuity of care than even our resurvey suggested.

Through this Day-Care Neighbor Service, we hope eventually to find ways of dealing with the core problems in the day-care triangle as they affect the child.

[1] Child Welfare League of America: Day care and related facilities. New York. January 1965. (Mimeographed.)

a public child welfare agency's experience in developing . . .

FAMILY DAY CARE FOR CHILDREN

FRANK A. FOLEY

In 4 years of operating a family day-care service as part of its public child welfare program, the Division of Child Welfare of the Monroe County (N.Y.) Department of Social Welfare has learned considerably more about the value of the need for a family day-care service in the community and the vicissitudes of getting such a service under way than it did at the outset. Originally begun as a service for mothers in the public assistance program, the service is now offered, on a casework determination of social need, to families throughout the community.

With the industrial city of Rochester as its core, Monroe County has a population of about 500,000. About one-tenth is nonwhite. Employment is relatively stable. The median income for all families is $7,000; but 10 percent of the families have incomes under $3,000 and 1.5 percent are receiving public assistance.

In our community, interest in the need for a service to provide day care for children in family settings originated with the Monroe County Council of Social Agencies, the coordinating body for the community's 99 public and voluntary health and welfare agencies—including two Community Chest supported day-care centers. During the 1950's, the council's Family and Children's Division—representative of 35 casework agencies—had frequently discussed the need for such a service for children for whom group care in a day-care center was not advisable but whose family situation required that they be cared for away from home during the day. The chief concern was for children from families in which the social situation—interpersonal conflicts, illness, or the strain on an overburdened mother—indicated that separation of child and mother during the day might be necessary as a step toward strengthening family life. In the fall of 1961, the council's newly formed Day Care Committee conducted a sample survey among local family service agencies—including the county welfare department's public assistance division—to determine the volume of such need.

The agencies were asked to list families who, in a given period, had been asking for help in making a day-care arrangement for a child or children, and another list of families for whom the caseworker would have chosen family day care if this service had been available, and the reasons why. The replies were startling. Caseworkers in the county welfare department's public assistance division alone reported 450 families who in their judgment could have beneficially used a family day-care service. The two community day-care centers, which had carried out the survey for the council, considered developing family day care as an adjunct to their group-care services, but did not have the funds to do so without additional Community Chest support, and this was not forthcoming.

At that time the county welfare department had no legal authority under State law to provide a day-care service or to use State child welfare services funds for the purpose. However, the imminent provision of Federal funds for day care appeared on the horizon with the introduction of the 1962 Public Welfare Amendments to the Social Security Act,[1] and a change in the New York State Social Welfare Law became a distinct possibility. Therefore, the State Department of Social Welfare encouraged the local welfare departments to plan to provide day-care services. In Monroe County we found that with cooperation between our public assistance and child welfare divisions, we could, with appropriate participation of the State Bureau of Child Welfare, get some family day-care service under way under existing State law and even before the Federal funds, appropriated in 1963, became available.

The plan was for the public assistance program, which already allowed an item for group day care to

be included in the budgets of recipient families needing this service, also to allow the inclusion of an item for the day care of children in families approved as day-care providers by the State Bureau of Child Welfare. Family day-care homes would be recruited and studied by the staff of the local child welfare services program and those found promising referred to the area office of the State Bureau of Child Welfare where responsibility for approving or disapproving the home would rest. The final decision would be made after a member of the State child welfare staff had visited the home.

Our initial program was, therefore, confined to providing service to families in the public assistance program. In the beginning it was limited to those who were living in the two census tracts where the council's survey had indicated the need for day care was greatest.

Before we got under way, we had some difficult planning sessions because of differing points of view between our public assistance and child welfare divisions on how the day-care families should be paid for their services. The public assistance division fought hard for adhering to its principle of including funds for all supplies and services budgeted for a family in a direct cash payment to the family head, who is then responsible for paying the vendor himself. The child welfare representatives held firm to the principle that families approved by the agency to provide care to other people's children—whether full-time foster care or day care—should be paid directly by the agency, since the foster mother or day-care mother works under standards and policies set by the agency and not by the child's parents. In the end the point of view of the child welfare representatives prevailed and a system for authorizing direct vendor payments was devised.

Getting under way

On July 1, 1962, Family Day-Care Service became an established unit within the child welfare division of the Monroe County Department of Social Welfare. It was staffed by an experienced child welfare supervisor with full graduate training. In the early months of the program she handled all its aspects alone.

Initially, the supervisor spent most of her time publicizing the agency's need for family day-care homes and recruiting families to provide daytime child care. She prepared a fact sheet which she distributed widely among groups of social workers, nurses, doctors, clergymen, and laymen, including women's clubs, boards and staffs of character building agencies, and professional organizations. She also began a reference library on day care for use by professional staff members and prospective day-care mothers.

General case supervisor in the Division of Child Welfare, Monroe County (Rochester, N.Y.) Department of Social Welfare, for the past 2 years, **Frank A. Foley** has been with the division for the past 11 years, first as caseworker and later as case supervisor. He received his master's degree in social work from Fordham University in 1958.

Before long the supervisor became very busy handling inquiries and applications from prospective day-care mothers. But referrals of families for service trickled in slowly.

The first referrals were almost all for the care of Negro children. Just as the agency had always had difficulty in developing boarding and adoption homes for Negro children, so it found difficulty in locating family day-care homes. It had established a rule that every day-care home must be within walking distance of the child's own home. This presented a real difficulty since these children lived in the city's most blighted areas.

The day-care supervisor involved all sorts of people in homefinding—school, church, housing authority, and settlement personnel—and finally succeeded in securing family day-care homes for Negro children. Then came the surprise. She discovered that the families for whom she had been making these plans had not waited for the agency but had found jobs and had taken themselves off the assistance rolls. Since at that time the family day-care service could only be offered to public assistance recipients, the agency could not offer these families the supervised day-care homes that had been found for them.

Another surprise was the scarcity of referrals from the public assistance division. However, this gave the day-care supervisor an opportunity to make thorough studies of each family referred for service and of the prospective day-care home. Then came another frustrating surprise. Many of the families who were referred for the family day-care service did not want it! In many instances the family's public assistance worker, noting inadequacies in the care provided a child in his own home, had apparently thought of day care as a panacea for his prob-

lems. Moreover, while referrals for day care had not been made simply to get the mother into the labor market, some of the mothers thought they were. And indeed some of the referrals could have resulted not in helping the mother to provide better child care, but in her abrogation of her child-care responsibilities.

In interviewing many of the mothers referred for the service, the family day-care supervisor found them tense and suspicious. Some of them seemed to think the agency was trying to get their children away from them. When they learned that the service was available only to assistance recipients, they saw it as something not quite respectable.

Another surprise, however, was more encouraging. Some highly disorganized parents who had very damaging relationships with their children but who had resisted suggestions for their placement in foster care accepted the offer of family day care. In some instances this proved to be a successful step toward badly needed full-time separation of parent and child. In other instances, however, the mother lacked sufficient strength to get the child up and dressed and to the family day-care home, although it was in her own neighborhood.

Because so few suitable referrals were made by the public assistance workers covering the two census tracts to which the service was initially restricted, the service was soon opened to assistance recipients throughout the county. Still very few referrals were made.

The discrepancy between what the day-care survey had led us to expect and the number of referrals received obviously arose from the realization of public assistance workers, after the program got under way, that some of the families they had originally thought could benefit from day care were either not able or not ready to use such a service. It became clear that a great deal of casework was necessary to help families benefit from it.

Types of families served

In December 1963, Federal funds for day care became available for the service through the State Department of Social Welfare. We were therefore able to enlarge the day-care staff with the addition of two caseworkers and to extend the service to families needing it, whether or not they were on the assistance rolls. Soon the unit was serving many mothers whose motivation for employment was high but was accompanied by considerable pathology in family relationships. At present the family day-care caseworkers handle intake, homefinding, supervision of the day-care home, and, except in some cases already being served by other child welfare workers, continuing casework with the child's own parents.

Today the families who come to the unit for placement of their children in family day care can, for the most part, be classified into three groups:

1. Young families in which the father is a graduate student in one of the local institutions for higher learning and the mother, the main breadwinner. For example:

The A's are young parents of a 4-year-old child who are expecting a new baby in a few months. Mr. A is one of several graduate students who have sought family day-care service. Mrs. A is employed as a clerical worker and supports the family. In spite of the fact that these young people did not plan to have children until the husband finished his schooling and that they are deeply in debt and have some difficulties with their own parents, they discuss their problems in a matter-of-fact way and do not express feelings of anxiety about them or about the new baby. Although their 4-year-old little girl has been cared for by numerous substitute mothers since her birth, she is making a good adjustment in the family day-care home provided by the service.

2. Families of divorced parents in which the employed mother carries full responsibility for rearing the children. For example:

Mrs. B is an attractive, intelligent, warm, and stable 32-year-old mother of two children ages 8 and 2. She experienced a very stormy marriage with an immature husband who acted out his hostilities in a flagrant manner. Both she and the children bear emotional scars. Even now Mr. B uses his visiting privileges with the children to punish their mother by trying to turn their affections from her.

Mrs. B and the children now live with Mrs. B's parents, who are both employed and who complain that the children make them nervous. Mrs. B's 8-year-old daughter has exhibited some reactive behavior, anxiety, and poor school adjustment, but has improved since settling into family day care. Mrs. B uses her relationship with the caseworker to ventilate her feelings and to plan for her own and the children's adjustment to life with the grandparents, the family day-care mother, and Mr. B's continuing and disturbing visits.

3. Families with rather severe social malfunctioning. For example:

The C's are young 24-year-old parents of a 6-month-old child. Both parents have extremely dependent personalities and have great difficulty in expressing their feelings. Mrs. C uses the baby to hold off her husband's attention. Mr. C acts out his inner stress through excessive activity and busy work. When they applied for family day care for their child, the C's were nearly overwhelmed by financial stress. They reacted to

this by further constricting their feelings and by seeking employment for Mrs. C.

In the casework interviews Mr. C was initially hostile, but now pours out his troubles with apparent relief. Mrs. C, on the other hand, strictly controls her feelings and has a very flip attitude toward the caseworker. The baby reflects the family strain by extreme tenseness, constant crying, and demands for attention in the day-care family, as well as by the physical symptoms of allergy and diarrhea.

We also serve families who come to us because they want to "park" their children so that the mother can go to work to bring the family a second salary. We believe that such families need our service, but in offering it to them we ask the parents to involve themselves in goal-directed planning.

In all cases the agency provides casework help to the family not only at the point of admission to the service, but also on a regular basis during the entire time the child is in care.

The caseworkers in the service also provide support to the day-care mothers to help them to understand and withstand the behavior of children who are reacting to problems in their own families and to the daily separation from their parents. We hope to experiment in the future with group meetings for training day-care parents.

Problems and promise

In short, in our 4 years of experience in establishing and operating a family day-care service we have encountered problems requiring difficult policy decisions in four areas:

1. Administrative procedures regarding certification of day-care homes and methods of payment. Although the methods we adopted were difficult to work out, they are now operating smoothly.

2. Recruitment and training of day-care families. We have stuck by our decision to place children in the same neighborhood in which they live, although this has added to our recruitment difficulties.

3. Intake. While we see the family day-care placement as part of a total family casework service, we have had difficulty arriving at a sharp definition of intake policy. In other words, the questions still arise: Should we limit our services to families requesting casework service because of malfunctioning in the family? Or should we also serve parents who resist casework help and wish only to be provided with a reliable day-care home for their children?

4. The use of the agency's casework staff. Because of the chronic shortage of professional social caseworkers in a public agency, the question also arises about how much casework treatment the family day-care service should provide. In other words, when the agency receives a request for day care from a family in which there is serious pathology, should the child be placed in family day care and the parents referred to the voluntary family service agency for casework help? Or should the casework treatment be provided by the public agency's family day-care caseworker? We believe that sound practice requires the second alternative for we see the day-care placement as an integral part of a total casework service. However, shortage of professional caseworkers in the public agency makes this level of service difficult to provide. The goal will probably not be fully achieved until the public agency has staffing requirements and salary levels high enough to attract and retain more highly skilled personnel.

In spite of these difficulties we are convinced that the family day-care service is an important addition to our public child welfare program's efforts to strengthen family life. Today we have 27 children from 20 families in family day-care homes, and 21 children awaiting placement. Those in care range in age from 2 months to 12 years, but the majority are under 5 years of age.

All are children who need the service either because being away from their families during the day is a therapeutic necessity, or because their mothers are determined to go to work and without our provision of a supervised day-care family would be likely to fall back on a hit-or-miss, and hence, hazardous child-care arrangement.

Our experience has convinced us that a public agency is performing a real service to children when it sets up a family day-care program, *if* it accepts children for family day care only if this is the best plan that can be made for them, and *if* the agency is able to provide skilled social caseworkers for recruiting and sustaining day-care homes and for working with families to remedy many of the situations which make the day care necessary.

[1] Public Law 87–543.

RONNIE GORDON

A NURSERY SCHOOL IN A REHABILITATION CENTER

For the past 4 years, the Institute of Physical Medicine and Rehabilitation, New York University Medical Center, has operated a school for preschool-age children admitted to the hospital as inpatients for diagnostic evaluation or therapy, or both. An integral part of the institute since 1965, the school grew out of a 1-year experiment to create a "caring situation" for children. It has four main responsibilities:

1. To stimulate the intellectual, social, and emotional growth of the children it serves.

2. To provide the institute's staff—physicians, psychologists, social workers, nurses, and speech, physical, and occupational therapists—with an opportunity for acquiring realistic ideas of how the young child's adaptive and cognitive powers function.

3. To compare the responses of handicapped preschool children with those of normal children.

4. To evaluate learning disabilities in handicapped preschool children and to initiate therapeutic measures in the preschool period.

When we began to set up the nursery school as charged, the educational consultant, Jessie Stanton, and I were uncertain about how we would have to modify educational procedures, methods, and materials to fit the school into a medical framework. We did know, however, that each child's program would have to fit in with his appointments for therapy and that each program would have to be noncontinuous and different. We also questioned the possibility of effectively serving a constantly changing class of children of varying chronological and mental ages, endowment, and experience whose development was impaired or interrupted in many ways. The pathological and physical disabilities of the children range from minor to severe; the level of their intelligence, from grossly defective to superior.

The school, which began in the children's dining room, will have its own especially designed quarters as a "laboratory for the study of learning dysfunction" in the institute's new research wing because the medical staff has found its program valuable. From our experience, we believe that the program has also been of value to the children and that any success is based on flexible and sensitive planning for the entire program and for each child's program.

Interdisciplinary coordination

Coordinating our work with that of other disciplines is an important part of the program. This begins on admission, at the time the child and his parents are seen by the resident doctor, the social worker assigned to the case, nurses, and administrators. If the child is of nursery-school age, his parents are asked to bring him into the school. Whenever possible, I, as director, talk with the mother to learn what I can about the child's home-play pattern, favorite materials, and special interest, and to observe signs of the quality of the parent-child relationship.

The social worker, who is in the best position to have a full view of the child as a member of a family and a community, tells the nursery school staff what she has learned about the child's needs and the parents' desires and expectations for him. The nursery school staff also works with the social service department, when requested, to find the best educational

resource in the community for the child. When the child is discharged from the institute, a summary of his progress in the school and recommendations for further schooling are attached to the final report sent to the school or training center to which he is referred.

The nursery school's relationship with the center's occupational, physical, and speech therapists is functional; that is, it reinforces the therapist's "teaching" by incorporating his goals into play situations.

About 4 days after admission to the institute, members of each professional staff meet to report on the child's developmental status. After these evaluations, each child is assigned to an individual program of half-hour periods of therapy. One child's program may call for three periods of paramedical therapy every morning—one each in speech, occupational, and physical therapy—and 1 hour or 2 half-hour periods for educational therapy. Another's program may call for only a half-hour of physical therapy, and 2 hours for school. A child will follow this program until discharge (the average stay is 6 weeks).

The physiatrist makes specific recommendations for nursery school attendance similar to those made for medical therapy or speech training.

At weekly staff meetings thereafter, the nursery school director, using the normal child as reference, appraises the patient's progress and on the basis of this report the school's staff draws up educational plans for him.

The nursery school operates on the theory that the hospitalized, handicapped child can be helped to grow emotionally and intellectually in a warm and stimulating environment in which he is free to express his feelings and which offers him opportunities to accomplish and to experience pleasure and success. Therefore, we are trying to give the children:

• ***An opportunity to use materials*** from which they may derive satisfaction, enjoyment, and feelings of mastery. They are offered: (a) sensory experience with water, play dough, clay and plasticene, and finger paints; (b) creative art activities with a variety of art media; (c) experience with blocks, puzzles, and manipulative toys to help them develop ideas of space and organization; (d) an opportunity, through dramatic play in a housekeeping corner, to relive and recreate home and hospital experiences and to release feelings about these experiences; and (e) an introduction to the physical world through simple experiments with water pressures and levels, magnetism, and flotation.

• ***Encouragement in the use of expressive language*** as a means of communication.

• ***Exposure to music and literature*** stimulating and meaningful at their age.

• ***An opportunity to be with other children***—to learn the gratification of being part of a group and the controls required of a group member.

The nursery school staff consists of a teacher-director, a teacher, and one assistant. Although there are usually 15 children in the preschool program on any 1 day, each half-hour session involves no more than 6 children.

The curriculum followed and the materials selected each day are influenced by weekly admission changes; the composition of the class at any half-hour period is arranged as meticulously as possible to afford each child an optimum working environment with other children at his level. The temporary composition of each session makes flexibility in program imperative, as do the variations in the children's neurological and physical status, chronological ages (2–8), and mental ages (1–5). When a child needs a one-to-one relationship with the teacher, his need is met. If he cannot benefit from group experience or if he disrupts the group, a tutorial method is used in a corner of the room, free from distraction.

When a teacher tries to educate a child rather than just to teach a subject to him, she has no standard methods or technique to elicit optimum responses from different children. This problem is magnified in our nursery school because the differences in functioning are influenced by the children's pathology. A teacher of abnormal children must first know normal children well to recognize the effects of the child's defect on his ability to perform. She has to understand what he has in common with normal children and how to build on this in his program. This enables her to find the elements of a maximal learning

Since 1962, **Ronnie Gordon** has been on the staff of the Institute of Physical Medicine and Rehabilitation, New York University Medical Center, as director-teacher of the preschool developmental program she describes in this article. A graduate of the Bank Street College of Education, she previously worked as a teacher and as an administrator in nursery schools for normal children.

environment for each child by using new methods, improvising materials, and experimenting.

Understanding the organized information each child brings with him is a demanding and difficult task for the teacher. Yet on her understanding hinges many decisions concerning adaptations in technique, methodology, and curriculum.

Experience has shown that a teaching method used successfully with a child suffering from muscular atrophy is not successful with a child suffering from cerebral injury and that a teaching method successful with a mentally retarded child may not be successful with a brain-injured child whose retardation is only spotty.

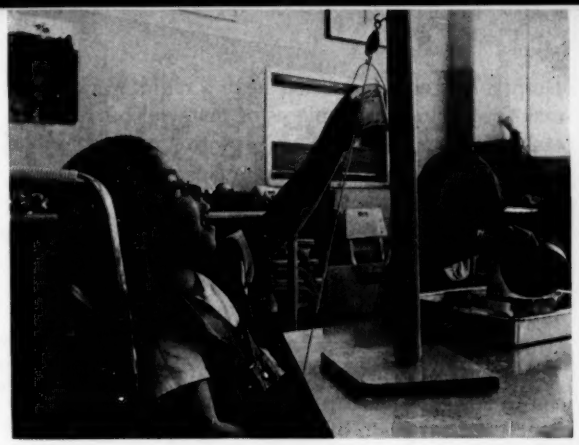
We try as much as possible to concentrate on the area of his disability, not just to encourage him, as an emotional compensation for his disability, to excel in areas in which he is well-endowed. Many children in our nursery school have perceptual deficits which interfere with their ability to determine relationships between things and high and inappropriate levels of distractability. Such children lose track of the task at hand because they become overly involved with detail, and do not see the goal. They seldom evaluate situations correctly and make inappropriate and socially unacceptable responses.

We find that when given a typical wooden preschool puzzle, a child with this type of brain injury is frequently content to turn the plaque over and empty the puzzle of its pieces. If he goes further, he tries to select the correct piece only on the basis of color or a detail, or a tenuous understanding of the relationship of the part to the whole. He does not integrate detail and the whole, and uses tactile clues without visual aids. He often places pegs in a board by touch only. Therefore, the teacher tries constantly to help him integrate the clues of all the senses. To do so she must add more details to the task. For example, with a peg board, she may add a color sequence to follow and a pattern to imitate.

Use of materials

Despite the need to make many adaptations for our children, perhaps the most revealing experience of the school has been the reinforcement of our confidence in good, well-selected, and well-presented educational materials as tools to stimulate *all* children. Our children, though exceptional, respond with interest, within their limitations, to play materials that appeal to all children.

Easy access to materials is more important to handicapped children than to normal preschool children. Because the child's reach is often restricted by his posture in a wheel chair, spasticity, prosthetic arms, or partial paralysis, we place materials at the edge of tables, along with supplementary tools to help stimulate an extension of his activity.



This child with muscles weakened by an attack of meningitis uses a pulley to play with a cup of salt, thus getting needed exercise while having the fun of "sand play."

Because standard tables are inadequate as play surfaces for children in wheel chairs and a work surface that surrounds the child is the most effective design for play, we have designed a table, adjustable in height, with a capacity for six children in wheel chairs to stimulate group interaction. This design will also be used for a sand-and-water table; the depth and indentation of its trays will be shallow enough for easy access to materials.

Play dough has proved to be the most successful medium for manipulative play and tactile experimentation (clay and plasticene are too resistant to pressure for many children).

Over 50 percent of our children are afflicted with congenital or acquired cerebral palsy and have resultant defects in the neuromuscular system which cause deficiency in motor ability and often impairment of eye-hand coordination. Conventional educational materials must be modified if these children are to be stimulated and gratified and are to use play equipment successfully.

To compensate for the incoordination and restricted hand movements of some children, we give them puzzles with knobs on individual pieces, tape all papers to table surfaces, and use only large crayons. Manipulative toys are geared to the motor development level of a 12- or 18-month-old child. Aprons with extensions for covering braces are used for all art work and water and "sand" (salt) play.

Empty baskets are placed near a child working on tasks requiring many pieces of material because it is easier for him to put an object into a container than to place it on a slippery table surface.

Because children with general muscle weakness cannot manipulate conventional unit blocks or construction play items, we provide small, lightweight plastic and balsam transportation toys; small blocks, baby bottles, and coffee scoops for shovels; and miniature models of houses, animals, trees, and people.

Many of our children with cerebral palsy need a one-to-one relationship with the teacher and a very structured program of tasks and play. This is true of the children with the different types of brain damage that lead to difficulties in perception and organization and to hyperactive behavior. Following Cruickshank's experience,[1] we use materials which include well-defined figures in primary colors against a monochromatic background and form puzzle boards with inserts of basic shapes and configurations. We introduce shape discrimination problems in as many different ways as possible. Raised frames are used to outline the form. They add a third dimension to the boundary and offer a border identifiable by touch when visual impression is faulty.

In teaching the language arts, the teacher tries to be aware of the child's distractability level, short interest span, and poor ability to connect pictures with concrete objects. In selecting books for storytime, we choose those that will expand their restricted world: books that are short and well written, containing simple and realistic illustrations. We try to extend the child's general information with stories about community workers, transportation, domestic animals, food, shelter, and family figures. We take every opportunity to introduce the doctor, nurse, and hospital into stories, puzzles, and discussions. Our dramatic play equipment includes doctors' instruments, real and toy, and rubber figures of hospital people.

Results and problems

After 4 years of operation, serving over 400 children, we realize that our initial reservations about the quantity of "learning" that could take place in a transient nursery school setting were partly justified. Nevertheless, we believe that there has been improvement in most of the children who have attended. Growth has been greater in some children than in others—but, then, some came to the school less organically damaged than others.

We have seen signs in many of the children of an increased span of interest in play, deeper involvement in materials, broader areas of activity, the beginning of socialization and group awareness, a feeling of increased worthiness, mastery of simple skills, more independent action and initiative, aroused curiosity, and the growth of trust in their relationship with teachers, based on the respect and care afforded them in school.

Most of the children, as they become accustomed to the program, display an eagerness to attend sessions, a decrease in withdrawn behavior, a lessening of anxiety, and an increase in spontaneity.

As in most nursery schools, we provide parents, whenever possible, with opportunities to share in their child's education through observations and conferences. We try to help them understand the kinds of learning experience all children need to grow socially, emotionally, and intellectually and what this means particularly in relation to their child's disability. We also suggest home programs, with individual lists of materials and activities appropriate to the continuation and extension of the child's growth.

One of our difficulties has been in finding suitable nursery school opportunities for our patients after their discharge from the institute. We know that if a handicapped child is not offered *more* than the nonhandicapped child in stimulation, training, and opportunities to learn the lessons of socialization, the effects of his disability are almost certain to increase even though his original disability is not progressive. Nevertheless, unless a child is independent in ambulation, most nursery schools will not accept him even if his intellect is intact. Because we are limited in space, we focused first on the needs of the inpatients. In the new wing we plan to extend services to a selected number of outpatients in an afternoon therapeutic and research-oriented program. We are, however, conscious of the need for expanded and additional educational opportunities in the community for preschool handicapped children.

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[1] Cruickshank, W., et al.: A teaching method for brain-injured and hyperactive children. Syracuse University Press, New York. 1961.

homemaker services to families with young retarded children

IRENE L. ARNOLD
LAWRENCE GOODMAN

In an effort to bring together two social trends which have been slow to meet—the growing concern for the retarded in our population and the increasing recognition of homemaker services in helping families cope with situations of stress—two voluntary agencies in New York City recently carried out a 3-year project to demonstrate the potential contribution of homemakers and other home helpers toward preserving families of the retarded. Its results may suggest guidelines for the most effective, economical, and efficient utilization of such services in community plans for the retarded.

Established to examine systematically the effectiveness of homemaker and other home-help services to families with retarded children under 5 years old, the project was cooperatively conducted by the Retarded Infants Services, Inc. (RIS), and the Association for Homemaker Service, Inc. (AHS), with support from the Federal Children's Bureau.[1] Behind its establishment was the conviction that such services, perhaps with various levels of integration with casework services, have an important place in the chain of services required by families of the retarded at the various times in the retarded person's life.

How parents respond initially to the fact of their child's retardation will determine to a great degree the quality of their lifelong reaction to their child, whether or not he remains with the family. The shock of learning that their child will not develop normally may cause them so much inner turmoil—characterized by ambivalent feelings of guilt, sorrow, and disappointment—that they may want to cut themselves off from the offending object by immediately placing the child in an institution or by withdrawing from him emotionally. New and more lasting problems can be created in such a futile effort to regain a semblance of normality.[2] If the child is to be placed away from home, the effect of an insufficiently considered decision can result in later self-blame and other manifestations of unresolved inner conflict. Providing the parents with help at the crucial period following their confrontation with the fact of their child's retardation must be the first phase of any broad program for the retarded.

In planning to help families at such a time, the first concern, of course, must be with the accessibility of comprehensive medical and psychological evaluation of the child and of whatever treatment may be indicated. At the same time the provision of skilled casework counseling to the parents can mean for many of them the difference between workable solutions and destructive ones. But also of vital importance are the associated services which may be able to relieve parents of the overwhelming sense of burden sufficiently to permit utilization of other kinds of help. Here is where homemaker services may play a key role. Our purpose was to demonstrate how.

Procedures

The project focused on 35 families. All were drawn from new referrals to RIS. Twenty-four had been referred from general hospital clinics, six from the New York State Department of Mental Hygiene, three from clinics for the retarded, two from private physicians. The intake social worker's determination that the family needed homemaker service was the basis of selecting the family for participation in the project. The only criteria were that the family have a mentally retarded child under 5 years of age and appear able to benefit from the presence of a helper in the home.

Irene L. Arnold, left, is executive director of Retarded Infants Services, Inc. A one-time practicing attorney, she began working in the field of social welfare during World War II with the U.S. Committee for the Care of European Children and later with UNRRA. **Lawrence Goodman** is social work consultant to Retarded Infants Services and director of social work for the Mental Retardation Center, New York Medical College.

Of these 35 families, 9 were referred to AHS for a conventional homemaker service in which a caseworker and a homemaker, both on the staff of the agency, work closely together as a team; and 20 remained with RIS for service, which included the help of domestic workers called home aides recruited for the family by the agency and some limited casework treatment. A control group of six families received no service but were put on the waiting list for future service.

A clarification of the two terms, "homemaker" and "home aide," seems pertinent. According to the standards suggested by the Child Welfare League of America: "The distinctive elements of homemaker service are (a) placement in the home of a trained homemaker employed as an agency staff member, who works together with a caseworker in carrying out a casework plan to help restore and strengthen parental functioning, or otherwise assure that the child has the care he needs; and (b) use of casework as an integral part of the service. . . ."[3] Homemaker service, as thus described, is closely interwoven with casework.

Home aides, as used by RIS, also are assigned and supervised by caseworkers, but the emphasis is placed on their ability to do light cleaning and cooking and their experience in caring for children, rather than on working consciously with the caseworker to help restore parental functioning. The family may concurrently receive some casework treatment focused on helping the parents reach the best plan for the child's care.

Experienced homemakers from the staff of AHS who were selected for the project participated with the casework staff in a seven-session orientation program. These sessions focused on the condition of mental retardation; the differences and similarities between retarded children and normal children; and the kinds of parental responses they could expect.

Most of the home aides who took part in the project had had previous experience with RIS. Each was carefully prepared by the caseworker to be aware of the general dynamics of each case situation.

In each case the particular homemakers and home aides assigned to the families were selected on the basis of the caseworker's professional judgment.

The two treatment conditions were not set up for the purpose of measuring the efficacy of one service over the other, but rather to seek further understanding of the impact on families of direct assistance in meeting the burdens of the family's daily routines, whether or not this assistance is interwoven with continuing casework treatment. If improvement were possible without the close caseworker-homemaker teamwork, this would seem to suggest that homemaker services for families of the retarded might be offered at different levels of casework involvement, depending on the families' need, capacity, and readiness to use total services.

Instruments created for the study included a "family rating form" for measuring the quality of interaction within the family; and a "decision-making form" for evaluating the character and adequacy of the parent's decision about the retarded child at the close of treatment. At the end of the period of service, all participating families were seen by a social worker in a followup interview. In this the interviewer attempted to view objectively the carry-over effect of the treatment received.

Findings

Both the data secured from testing the case material with the measuring instruments and the data from the clinical followup showed improved functioning in the families served by either homemakers or home aides, in contrast to the families which received no service.

The family rating forms indicated that, in contrast to the control group, families served by AHS made important gains in their intrafamily relations as did families served by RIS, though there were some subtle differences between the two groups in the types of changes which occurred. For example, the AHS group showed a greater increase in friendliness among family members than the RIS group, but the RIS group showed greater development in rationality of conduct.

The decision-making forms indicated that families in both serviced groups rated much higher than those

in the nontreatment control group in the quality of plans made for the retarded child. Little difference existed between the AHS and RIS groups.

Similarly, the clinical followup of cases indicated a high degree of sustained gain in families which had received service, regardless of which agency had served them. Some parents who had become involved in relatively intensive casework were able to face openly some of their basic conflicts about their child. However, even families in which the parents regarded the casework they had received as superfluous, but who had a high regard for the help they had received from the homemaker or home aide, improved in intrafamily interaction. Also, the families who had had only occasional encounters with a caseworker focused on specific problems showed sustained improvement.

Thus the findings suggest that, in families confronted with the reality of retardation, help from a homemaker or home aide, selected and supported by a casework agency, can in itself be salutory.

The following two cases illustrate how this may be so at different levels of casework involvement.

The A family

Mr. and Mrs. A were referred to RIS by a diagnostic clinic. At the time of referral, their retarded child Amy was 4 years of age. Her brother James, age 9, had normal intelligence. Mr. A was unemployed because of a strike. Mrs. A said she was at the breaking point because Amy was completely unmanageable, could not be left alone at any time, and had proved to be a tremendous burden to James, who was charged with some of her care.

Both parents seemed immature, demanding, and manipulative. A severe marital problem had developed out of conflict around Amy. The mother was particularly anxious, describing herself as confused, forgetful, and fearful of harming Amy. Mr. A and his parents were pressing her to send Amy to an institution; Mrs. A was not yet ready to do so.

RIS referred the case to AHS, which sent a homemaker into the home. She was trained not only to assist the mother in carrying the burden of household management and child care, but also to observe changes in behavior and attitudes. Part of her role was to help find out whether or not Amy was educable.

Under the regular supervision of the AHS caseworker, the homemaker assumed a nurturing, maternal role with both the children and the parents, but she was careful not to encourage lingering dependency. Amy responded well to her special attention and soon began to show remarkable improvement. Mrs. A apparently had been too tense to handle her in a way that could bring out her potentials.

James, too, showed improvement. He had not only been relieved of Amy's care, but was also getting more attention from his parents. Soon he seemed less withdrawn and behaved in a more forthright and appropriately aggressive manner. Mrs. A seemed more relaxed, since for the first time in years she had some time for her own needs. The tension between the parents also relaxed a little, and both seemed to have less need to reject Amy.

The AHS caseworker kept in regular touch with the staff of the referring diagnostic clinic who soon reported that the homemaker services had helped clarify the condition of the child and the dynamics of the family situation. It was then agreed that the AHS caseworker would take over the family counseling role from the clinic and would attempt to bring about better relations between the parents by helping them both to a better understanding of the needs of their retarded child, of their normal child, and of each other. As a result, it became possible to enter Amy into a special day class for the retarded instead of into an institution.

This case exemplifies homemaker service in its complete sense. The steadying influence of the homemaker, working in close partnership with the caseworker, expanded the understanding on which a diagnosis could be made, thus making possible more appropriate recommendations for the child's management and care.

As is common with organically damaged children, Amy had responded negatively and with hyperactivity to the anxiety-ridden, erratic handling she had been getting from her parents, and thus her true functioning ability had been obscured. The consistent, well-planned approach of the homemaker helped the child function less destructively and on a higher intellectual level. The resulting decrease of tension in the home increased the parents' ability to make use of casework help. Thus, an institutionalization, likely to be harmful to both the child and the parents, was avoided.

The M family

The following case illustrates the provision of home help chiefly to relieve harried parents while they are mobilizing themselves to adjust to a severe emotional blow.

Mr. and Mrs. M were first known to RIS in 1962 after they learned that their 2-year-old daughter Ruth was severely brain damaged and hopelessly retarded. With the assistance of the agency the child had been placed in an institution. Recently the tragedy was re-enacted. RIS received a call from Mr. M, who was crying hysterically. His wife was in a hospital having an operation and he had just been informed by the family's pediatrician that his 7-month-old son John was also severely retarded. Mr. M seemed to be at the breaking point.

The RIS social caseworker made a home visit the next morning and immediately arranged for a home aide to go into the home to assist Mr. M in the care of both the retarded baby and the family's 5-year-old normal child. Within a few days, Mr. M had recovered sufficiently to go back to work.

After Mrs. M returned from the hospital, the home aide, a person of much warmth and sensitivity, remained in the home to help out while Mrs. M recovered from her physical weakness as well as from the emotional shock of the baby's retardation. At the same time, the social worker and the family pediatrician worked closely together to help both parents accept the diagnosis and again prepare for placing a child in an institution. Mrs. M also received help from the social worker in explaining the baby's condition to the 5-year-old.

Throughout our analysis of the project cases, the effectiveness of the help given by the homemakers appeared most clearly when, as in this case, it was extended to families in the early stages of their response to a crisis. By providing instant help with the burdens of daily existence, the home helper often made it possible for parents to begin to regain enough psychic balance to be able to use casework counseling and help with planning for their child's future.

Some conclusions

The nature of parents' early reaction to their child's retardation—often with the need to deny reality and to isolate all feeling—can block parents from entering into a therapeutic relationship with a social caseworker, as well as from being able to encourage their child's progress or create the kind of emotional atmosphere that can stimulate development. While not all parents respond to a crisis in the same way or experience trauma with the same intensity or duration, many do remain fixed in a state of emotional turmoil for long periods of time. Suppressed anger toward the retarded child, and toward fate in general, becomes internalized and thrust upon the self.

When such psychic turmoil is taking place, the introduction of a homemaker or home aide, who offers warmth and support and provides direct evidence of the community's desire to share their misfortune, can cut through some of the sense of hopelessness. Freed sufficiently to deal with the needs of other family members and to resume activity outside the home, the parents may then be able to perceive the retarded child with sufficient objectivity to consider alternatives in planning and to participate in the kind of continuing casework treatment that can build up the strength in the family. Thus the dynamic potentials of homemaker services go far beyond the practical assistance offered.

We found in the project that most families were enabled to maintain the child at home until a reasoned, reality-based decision about his future had been made. But even when parents proceeded with inadequate planning, the home helper's assumption of many of the responsibilities of the retarded child's care tended to mitigate their guilt and anxiety regarding their child.

Because existing homemaker agencies can obviously play a major role in helping retarded children and their families to a better life, community plans for comprehensive care for the retarded should incorporate such agencies into the overall design and goals of their programing. Ideally, these agencies should be able to provide home help flexibly, according to the varying needs of families of the retarded. Some families can benefit by home help which is not so closely interwoven with casework treatment as is required to help other families. Where such flexibility is not possible, home aide services might appropriately be offered by specialized agencies for the retarded.

While the project described here focused on the needs of families with young children, homemaker service should not be regarded solely as an emergency resource. Actually it is badly needed by many families on a long-range basis. The demands of a severely or moderately retarded child can be so consuming that at least part-time home help may be needed as long as the child remains in the home.

The complex needs of retarded children and their families require bold new planning that includes the creative use and adaptation of existing approaches to families in trouble. Agencies which specialize in service to the retarded must provide the direction that will encourage others to open up a variety of previously unobtainable services to families of the retarded.

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[1] U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: The value of homemaker service in the family with the mentally retarded child under five. Child Welfare Demonstration Project No. D–66. 1965.

[2] Begab, Michael: The mentally retarded child: a guide to services of social agencies. U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 404. Reprinted 1965.

[3] Child Welfare League of America: Standards for homemaker service for children. New York. 1959.

HOW CHILDREN FEEL ABOUT BEING PLACED AWAY FROM HOME

SIDNEY Z. MOSS

Most children in child-care institutions today have parents. In fact, they have been called "orphans of the living."[1] Thus, when a child is placed in an institution, he faces two difficult adjustments: mastery of the separation trauma; and adaptation to life in the institution. As a former institutional caseworker, I have had the opportunity to observe how some children and their parents can convert an experience of being torn apart into a process which has been described as "moving apart through growth."[2]

I have also observed how difficult this process becomes when children have not been well prepared in advance for the separation and placement, when they have not been encouraged from the beginning to express their true feelings about these two frightening experiences, and when their parents have not been helped to build and maintain a meaningful relationship with them during the entire period of placement. In this article, I will discuss the effect of repressed feelings on such children after they have been in institutional placement for many months or even years and the implications of this for an institutional casework service.

The children I worked with were in long-term placement in an institution for dependent and neglected children which had only recently begun to offer intensive casework services. Many of them had been separated from their parents through juvenile court action. Many had lived in families in which there was long-time parental discord, alcoholism, or mental illness, and most had been subjected to serious neglect or abuse. Others came from homes broken by parental desertion, separation, physical or mental disability, or death.

Feelings about separation

The two basic fears of a child are said to be of loss of parental love and of parental desertion. As English and Pearson have pointed out,[3] when children lose a parent, whether through death, desertion, or themselves being sent away from home, they go through a mourning experience similar to an adult's after the death of a loved one. But each child must work out his mourning process in his own way. This will be affected not only by the child's own personality, but also by his age, sex, cultural background, the quality of his relationship with the lost parent, and his previous experiences of loss. For example:

Maria, an older adolescent, deserted as a little girl by her parents whom she never saw again, still follows every rumor about their whereabouts, scours telephone books, sees her parents in many strangers' steps.

The loss of a father generally has a more significant meaning to a boy's development than to a girl's. Also, the loss of the mother has a different impact on a girl than on a boy.[3] For a boy, a father represents a model of masculinity with which he can identify as he works out his feelings of assertiveness, competitiveness, and independence. Moreover, having a father who can be depended on may help him develop the ability to accept authority in others when

appropriate. Similarly, for a girl loss of her mother represents a loss of an identification model. Also, since children, whether boys or girls, grow with certainty of their mother's love, loss of a mother or loss of her love (which to a child may be the same thing) impairs children's potential to trust in others. The resultant fear of rejection may become internalized as a fear of closeness.

As Charnley [4] has pointed out, unless children can freely discuss their situation at a time of parental loss, they are led to repress feelings of guilt, shame, ambivalence, and confusion about themselves and their parents and to withdraw into defenses of mistrust, fantasy, and denial. Since placement away from home means parental loss to a child, the child begins with a serious handicap. No matter how well prepared children are for the placement, separation from their parents is still a traumatic experience for them and evokes psychic defenses against the pain. Littner has shown that these defenses, if internalized, can impede the development of other relationships, encourage repetition of the past trauma, and inhibit growth.[5]

No matter how long children have repressed or avoided their feelings about separation, they need to become aware of them to grow not only as independent beings but also in relation to their parents. Children, however, have ambivalent reactions to the idea of discussing their feelings about past separation. On one hand, they thirst for more understanding of the past—particularly of how and why they came into placement. They want to fill in the unknown facts and feelings of their past to know more about themselves and what they want to become. On the other hand, they do not feel strong enough to bear the pain of exploring their feelings. Glickman[6] has observed that a child resists discussion of his feelings about separation because he is afraid to "lose all chance to return to the family, a hope he clings to in fantasy or unconsciously."

Often children who resist discussing their parents in the hope that they will change are those whose parents are most inconsistent and rejecting. These are the parents who talk about taking the child home but never make any plans, who promise to visit the child and do not, who rarely write to him, who forget his birthday, and who care little about the child and his needs. Such children suffer deeply since they are constantly confused about what to expect from their parents. But they cannot express their resentment because of their hope that the parents might magically change after all, or because of their fear that the parents might sever the tenuous connection they have. Such children may transfer their conflicting feelings about their parents to the institution itself. Although they wish to trust their parents to meet their emotional needs, they are not sure they can, and this ambivalence is repeatedly acted out in erratic behavior in the institution.

A child may also hide his feelings about separation behind a pseudo-mature objectivity. Outwardly, he is like an adult; inwardly, he is the child torn with yearning for his unmet dependency needs to be met.

Joan, a pre-adolescent in placement many years, believes intellectually that her mother, who recently married, has a right to live a life of her own; but at the same time she is terribly hurt, depressed, and confused by her mother's rejection and preference for a strange man over her.

Children also resist discussing their parents when they have no home to go to. This is often true when their parents are dead.

Children are very protective of their parents, ready to defend them against any criticism, direct or implied. Many feel so much a part of their parents that to reveal any negative feelings about them seems like an indictment of themselves. They often want to be like their parents regardless of the way the parents have treated them.

Sybil, recalling her mother, who was sexually promiscuous and alcoholic up to her death, literally worships her mother, as if any criticism of her meant complete rejection.

Children search for every scrap of attention they ever received as proof of their parents' love. They cannot bear to let their parents be considered neglectful or their love so weak as to have permitted separation to occur. Children cling to their old ties, no matter how destructive the parent-child relationship, in the absence of certainty about the new relationships available to them.

Children's resistance to discussing their feelings about their parents is also strengthened by the fact that a mere mention of parents reminds them of the reality of their placement and of their sense of abandonment, which they must deny to avoid pain. Some children accordingly meet mention of their parents with an air of indifference.

Johnny, an adolescent, has been in placement many years. He cannot remember his previous life in his parents' home. His mother died when he was 4 and he only vaguely remembers her funeral. His father is still living but rarely visits him in the institution. Johnny has built a wall around himself.

He has no interest in his father now or in connection with the future. A sullen, withdrawn boy, he bullies other children and tortures animals.

* * *

Jimmy, a 10-year-old child, was deserted by his father shortly after he was born. His mother placed him with a relative, whom he thought was his mother until she died. Then his mother immediately had him placed in an institution. Now Jimmy cannot remember his substitute mother. He has little feeling for his own mother except resentment that she placed him so quickly. He knows that his father is alive but prefers to consider him "dead." "What's the difference, he does not see me." Jimmy has made sexual advances to a child of preschool age. He now shows suicidal tendencies.

Some children resist discussing their parents because they do not want to give them up as objects upon which to project their resentment of the world. They need to reject their parents until the parents make up for their pain. Such children develop a superficial, exploitative, and demanding attitude which is carried into all relationships.

Mae, an older adolescent, was placed for institutional care by a deserted "father" who suspects she is not his, although he does not tell her this. Desperately wanting him to love her but unable to trust in his feelings toward her, which she senses as ambivalent, she denies any feeling of affection toward him. Playing on his sense of guilt, she demands money and expensive gifts whenever she sees him. He complies but with deepening resentment.

Some children resist discussing their feelings about their parents because no one has ever before been concerned about how they feel and they do not see why anyone should be concerned now. Others feel relieved in finding that the caseworker understands a little of what it means to be a child in placement but resent the fact that nobody discussed their feelings with them when they first came to the institution. Some express a feeling of futility, saying that discussions about their parents now can have little value except as painful reminders of the past and of the pointlessness of the future.

Feelings about placement

As Rose has pointed out,[7] many children having been neglected before the placement have had little opportunity to develop a capacity for creative adaptation under stress. Although the institution may offer such children the kind of security and consistent good care that are conducive to healthy growth, they need to discover the positives in the situation themselves before they can deal effectively with their pain. There is pain in their efforts to reconcile the fact of their placement with their parents' expression of concern for them; pain in finding their worst fears confirmed—that their parents did not love them enough to keep them—especially bitter if they have brothers and sisters who have been kept home; pain in not knowing if they will ever be back with their parents, who are often vague in regard to their intentions; and pain in feeling inadequate and helpless in an unpredictable world—a feeling expressed in the frequent question, "What will happen next?"

Most institutionalized children seem to have little idea of how and why they came into placement or what is planned for their future. Many do not remember at all how they came, who brought them, and how they felt at the time. This may be due to their swift acceptance for care, without appropriate preparation, explanation, or help in dealing with their pain. Their primary means of defense then was to repress all feeling.

Sometimes parents have been unaware of their own motivations and so unable to give the children adequate reasons for the placement. Some parents who in their childhood have themselves been placed away from home unconsciously earmark a child for placement out of a need to repeat their past in working out their own unresolved conflicts.

Joan, according to her mother, was born at the wrong time—when the mother was depleted physically and emotionally. When Joan's father died, her mother let the grandmother take care of her for a while and then placed her in the institution. The mother later remarried. Joan, now 12 years old, longs in vain to return to her mother, who continues to reject her. The mother has created the same situation with her child that she, herself, experienced as a little girl. She, too, lost her father, was quickly placed, and longed desperately for years to return to her mother, who remarried but had no room for her.

Sometimes a deserted mother has taken her revenge on the child.

Jane, whose father left home shortly after her birth, was placed in the institution at an early age because she was a constant reminder to her mother of the father's desertion. At the time of placement the mother said she could not handle the child until her husband returned. Actually, she had never wanted the baby, whose birth she felt was the cause of her husband's desertion. Jane, now 7, yearns for her lost father, but does not want to be returned to her mother.

Unable to accept the fact that their parents wanted to get them out of the home, some children blame the placement worker. They accuse the worker of talking the parents into it or stealing them when their

parents were out. A child may feel that his placement came about by accident, that if his mother had not needed to go to a hospital on a particular day the placement worker would not have come to get him.

A child may initially see the institution as providing protection. But as years pass without adequate planning for the child's future, the child tends to see the institution as a permanent provider and becomes increasingly dependent upon it. If he cannot plan for the unknown future or master the trauma of his separation, he drifts complacently in the present.

When the caseworker discusses the possibility of reunion, the children frequently express a desire to stay in placement. They are afraid to leave the security and dependability of the institution. This is especially true of children who have been in placement for a long time. They want to avoid the risk of a more independent life and the need to work out a relationship with their parents; but they rationalize their resistance to reunion and may say they want to remain where they are for several years longer so they can graduate from school with their friends or that they do not like the neighborhood where their parents live.

Some children deny that there is anything to prevent them from returning to their parents. They seem unaware of their parents' rejection or inability to care for them at home and fantasy that when they want to go home all they need to do is to ask their parents to take them. Other children blandly shrug off any discussion of going home to avoid the possibility of further anxiety and rejection. In fact, some children, emotionally drained by a long placement, may no longer be able to show much feeling for their parents.

Some children are realistic when the subject of reunion with their parents comes up. They have little faith in their parents' capacity and stress the value of security and dependability in the institution. They realize that their father cannot hold down a job or that their mother is unable to provide clean clothes, regular meals, and an adequate home for them.

Underlying some of the children's strong feelings of dependency on the institution may be the failure of the institution to encourage the parents to be actively involved with the child while he is in placement. The child's awareness that his parents seem undervalued may reinforce his own sense of inadequacy and lead to increasing reliance on the institution as a substitute family, at the expense of a developing sense of autonomy.

Identity problems

Children who have had little opportunity to express their feelings about separation and have had little sense of their own participation in the decision for placement tend to be anomic, with a diffuse sense of identity and little capacity for relationship. Having little idea of the reason for their placement, they have little sense of direction and consequently feel helpless. They have no plans for the future and when the caseworker brings up the subject they may ask, "Where were you when I needed you? It's too late now."

Even if the caseworker and the child develop a specific plan for the future, the child is likely to react with confusion, indecisiveness, and failure to follow through. When it is made clear to him that he is expected to follow through with whatever plan he has chosen, he may regard the expectation as rejection and react with anger or stubborn refusal.

The present may have little meaning for an institutionalized child. Said one, with a shrug: "What's a birthday? One day is just like another—like death."

Time spent in placement with no distinct goals can be death-like. Only a succession of discrete moments without continuity and direction, it fails to provide the momentum for growth, and the child is unable to proceed toward self-fulfillment. Lawder has pointed out how a child long in placement may retain the same symptoms of distress that he showed at the beginning.[8] He cannot move beyond that point until he has been helped to understand the reason for and the goals of the placement.

A child who has only a vague sense of identity feels an aching loss and a desperate need for others to make up for what he does not have, or to support what he does have. Yet, filled with both rage and self-hate, he is not sure he can trust in any human

Sidney Z. Moss, now chief psychiatric social worker at the Children's and Adolescents' Psychiatric Clinic, Philadelphia General Hospital, made many of the observations he reports here while director, from 1964–65, of the Carson Valley School, a home for dependent children in Flourtown, Pa. A graduate of the University of Pennsylvania School of Social Work, he has worked in a number of children's agencies in Philadelphia, including the Society to Protect Children and the Child Guidance Clinic.

relationships. His energy is dissipated in clinging to others in an insatiable dependency bond, which gradually eats away his capacity to be a person in his own right.

Such a loss of identity prevents a child from seeing himself as the key person in charge of his own fate. Struggling with loneliness, he develops few interests, sees things only in black and white, "reacts to" rather than "feels with" other people, and tends to regard people as objects to fill immediate needs. Having little sense of autonomy, he thinks mainly in terms of what others want him to be; and having little sense of purpose he marks time and avoids full use of the institutional program or staff relationships. Since growth is possible only when time is, to employ an expression of Thomas Mann, "sanctified by its creative use," such a child needs help in developing a sense of control over his time or destiny so that he can use the placement experience creatively.

Some implications

Thus, in working with institutionalized children, it is essential to deal with their feelings about separation from their parents as early as possible before they are blocked by repression. Ideally, casework treatment with this focus should begin well before placement, or, if this is impossible, immediately afterward and should be carried on as long as the child is in placement, for pain and psychic conflict inflicted by parental loss are deep and tenacious. However, even when a child has been in placement a long time without having a chance to discuss his feelings freely, a sensitive caseworker may help him do so.

While the institution's caseworker may also help the child accept his parent's decision to place him away from home, the placement agency should impress upon the parent the importance of giving the child the initial explanation so that he may gain strength from the feeling that behind the decision was concern for himself. Similarly, the agency should make it clear to the parents that they are expected to keep in close touch with their child during the whole time he is in placement so that he can feel strong in his identification with his family, the source of so much of his individuality.

The agency's goals in accepting each child for placement also should be made clear to his parents, or parent, at the beginning of placement so that they will understand the importance of their full and continuous involvement in support of the agency's plan for the child. A clear understanding of what is expected of them can help motivate parents to maintain a positive connection with their children through responsible visiting, letter writing, backing plans to meet his medical needs, and working with the staff in his behalf. When parents are so involved, the children can learn to see the parents as they are and to value their strength and respect their limitations. This helps them make better use of the placement experience.

An institution must develop understanding of what it can expect from parents. Some parents may not be able to support a placement plan; some may be able to relate to their children in placement but may be against reunion; others may be realistically hopeful of having their children at home once more; still others may need help to relinquish their child so that he can be free for adoption or a foster-home placement.

If it becomes evident that a child may need to stay in long-term institutional care, this should be made clear to both parent and child, but the plan should be reviewed periodically.

Whether parent and child can be reunited or need to stay apart, the growth of each separately and in relation to each other is the placement goal.

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an essay review . . .

THE DEVELOPING INFANT

SYLVIA BRODY
Director, Infant Development Research Project, Department of Pediatrics, Lenox Hill Hospital, New York

Infant psychiatry was almost a brand new field when René Spitz published his earliest reports of hospitalism and anaclitic depression among infants living in institutions.[1] His data made clear that psychopathological developments occurring in the first year of life could be traced to intense or extensive emotional stress and deprivation, and that they set limits upon subsequent maturation or even upon life beyond infancy.

Then came his important monograph on the smiling response, coauthored by Katherine M. Wolf.[2] His subsequent publications have been composed mainly of clinical and theoretical additions to these data.

Spitz already has had the satisfaction of seeing many followers elaborate or refine his explanations of infant behavior. One therefore might hope that his latest book, "The First Year of Life,"* would offer an organized summary of his more than two decades of work on the subject, and would present his view of questions still needing clarification. Unfortunately, the hope is not fulfilled.

The first part of the book describes psychological achievements of infancy which Spitz believes mark milestones in the normal development of object relations—that is, the quality of mental representations of people and things outside the subject's own body. The second deals with psychopathological conditions found among institutionalized infants. The third, an addendum by a collaborator, Geoffrey Cobliner, compares some classic psychoanalytic concepts about infantile mental life with the theories of Piaget.

In the first two parts of the book, Spitz recapitulates the major theses he advanced between 1945 and 1964, but he provides no adequate account of which observations yielded which data. Yet the findings serve as bases for broad and unwarranted generalizations about cultures as well as about infants.

Still, this book presents major contributions to the psychology of infants. The theories concerned with pathology have had the most direct influence upon other investigators. Since most infants are outside institutions or foster homes, however, it seems well to deal here with Spitz' considerations about normal development, especially with two of his basic theories: the perceptual capacity of the young infant, and the "organizers" of development in the first 15 months of life.

Infants' perceptions

Spitz describes two types of perception in infants. The first is an undifferentiated perception of a mass of body sensations ("coenesthetic perception"). It is "extensive, primarily visceral, centered in the autonomic nervous system," and is "manifested in the form of emotions." The second, the distinguishing perception of outer stimuli ("diacritic perception"), is achieved through the peripheral sense organs as the infant develops.

Spitz regards the mouth as the central organ allowing for a transition from the primary undifferentiated *reception* of sensations to the differentiating *perception* of external stimuli. However, it is questionable whether the mouth is the earliest perceptual organ. Data fast accumulating suggest that the eyes and ears play a concomitant early perceptual role. Spitz says that a "shift from contact perception to distance perception" occurs through the infant's staring at the mother's face while he sucks the nipple. This implies that infant feeding experiences are far more uniform than they are. In defense of his thesis, Spitz says: "Neither [direct observation nor experiments) will yield much information from the neonate, for his behavior is random, unstructured, and his responses are inconsistent"; and he indirectly supports this statement by reference to the work of Fantz and of von Senden.

Fantz has produced increasing evidence that neonates have innate form perception.[3-5] Spitz argues that, although Fantz' subjects did visually distinguish differences, this does not mean that they perceived patterns. Mere seeing, he says, is not form perception. By just assuming, however, that infants do not perceive but merely see, one cannot nullify the significance of Fantz' findings, which indicate the existence of cortical functioning from birth.

Even more strange is Spitz' discussion of von Senden's studies of persons who were born blind and of necessity developed nonvisual modes of perception and who in later childhood

*Spitz, René A.: The First Year of Life International Universities Press, New York. 1965. 394 pp. $8.50.

or adulthood gained vision through surgery.[6] Von Senden's subjects found it almost impossible to make use of their new visual capacity. Spitz maintains from this evidence that visual perception is not innate. A biological comparison of the visual learning of the once-blind to the visual responsiveness of the newborn hardly seems justified.

The organizers

Spitz has taken his second theme, the concept of "organizers" from embryology, in order to describe three achievements during infancy as being of peak importance for the infant's development of object relations. The three achievements are: the responsive smile which appears at 3 months; an "anxiety" in the presence of strangers, at 8 months; and a head-shaking "no" gesture, at about 15 months. When currents of development are integrated with functions and capacities resulting from maturation, Spitz says the outcome is a restructuring of the psychic system on a higher level of complexity: "This integration . . . when successful, leads to what I call an 'organizer' of the psyche."

In embryology, an organizer is a substance that serves as a tissue transformer, the transformations being fixed by the constitution of the tissues. It is neither an integrative process nor an indication of a process, but something which induces a process of structural differentiation, and which may lead to the formation of additional organizers.[7]

Spitz' use of this concept to build a "genetic field theory of ego formation" does not succeed despite its clinical acumen. For example, the responsive smile at 3 months seems to be a maturational attainment rather than something that induces a structural differentiation. Spitz seems to overlook his own findings regarding the developmental deviations of infants deprived of appropriate stimulation, findings which show that stimulating experiences are almost prerequisite to the appearance of the smile. Nor does he make any reference to the numerous studies, following his own with Wolf,[8] of the vicissitudes of the smiling response before and after the third month of life among infants in various kinds of environments.

Spitz' second "organizer," the "8-month anxiety," has had even less confirmation. Several observers have indicated that the symptoms of anxiety in the presence of strangers that may appear at about 8 months are not universal. "Anxiety" may be, in fact, a misnomer for what does appear.

Like Benjamin[9] we have observed that most normal infants around this age do not show an emotion resembling fear, but often show a cautious visual inspection of strangers or a temporary freezing of social response, without any turning away at all.[9] Frank anxiety at sight of strangers at about 8 months may be developmentally inappropriate, an excessive reaction.

The "no" response

The third "organizer," the head-shaking "no" gesture, is said by Spitz to mark the infant's first achievement of an abstract concept, at approximately 15 months of age. He believes that the precursors of this achievement are the neonatal reflex rooting pattern—a search for food—and at 6 months the head movement from side to side which has the converse function of food avoidance. While some elements of this theory may be valid, as presented it contains numerous factual errors. For example:

1. ". . . every 'No' of the mother represents an emotional frustration for the child." The fact is that often it takes a long time for the toddler to recognize the "no" as anything but a stimulus for gleeful repetition of the disapproved act.

2. "The six-month-old baby, when he is satiated . . . turns his head from side to side, avoiding the nipple, or the spoon, in one word, the food—with the very same rotatory movement which at birth served him to seek food." Among 120 infants of this age observed (in film) during entire feedings,[9] only 5 showed this head-shaking behavior: 4 between willing acceptance of spoonfuls of food, and 1 on waking from sleep.

3. "The mastery of the 'No' (gesture and word) . . . presupposes that he has acquired the first capacity of judgment and negation." Actually, babies may make many judgments before this—they decide which objects belong in mother's purse or in the refrigerator; which are edible or tearable, and which are not. They note essential relationships though they cannot yet isolate either by gesture or word the quality that establishes the relationship between objects. Perhaps the 15-month-old infant's "no" means mere refusal rather than negation.

4. "With the acquisition of the gesture of negation, action is replaced by messages, and distance communication is inaugurated." What of the earlier visual and auditory messages that mother and infant send to each other, using facial expressions, or sounds that entreat, complain, command, or reassure?

5. ". . . the first abstract concept [expressed in the semantic symbol of "no"] is acquired with the help of a displacement of aggressive cathexis [here meaning negative emotions toward objects]." Apparently, Spitz uses the term *abstract concept* to mean the idea that something can *not* be, rather than as a classification made on the basis of similarities between objects. True, a *selection* of the object-to-be-refused is accomplished by aggressive energy and a resulting *classification* is expressed in a symbol. But the "no" of refusal or resistance indicates only that objects are to be fended off, and not that they have any class relationship.

Object relations

Throughout his work Spitz has drawn attention to infantile maladaptations that may simultaneously influence both emotion and intellect and has shown that an adequate theory of normal infant development must encompass the progression in the infant's development of affect and of object relations. But Spitz moves too quickly when he postulates a "field theory" of object relations by connecting three isolated infantile responses in the first 15 months of life, that have not all been proved to be of great importance. These responses may reflect or have a bearing on the state of an infant's relations to the outer world, but many others may be found to be equally, or more, significant.

Actually, only the first of the three responses, the smile, is an approach response; the other two are avoidance responses. This suggests that these particular responses made such a strong impression upon Spitz because almost all of the infants he studied were not

living at home and were lagging or deviant in social development.

Spitz' brilliant work on the responsive smile at 3 months perhaps made it natural for him to regard this achievement as the first peak in the development of the infant's relations to the outer world. The subsequent disappearance of the smile in the second half of the first year, exaggerated to an "anxiety reaction" among infants who were either emotionally neglected or erratically stimulated may have seemed conspicious enough to be a second peak. But between the ages of 8 and 15 months, a normal infant makes other enormous developmental advances. Most obviously relates to his growing awareness of others as separate from himself are his ability to walk away from and back to his mother; to make playful imitations of sounds and gestures; and to play hiding games.

A paradox

No one has reacted with displeasure to Spitz' reports of the normal appearance of the responsive smile in the third month of life. In contrast, many have been appalled to learn of the severe psychological damage suffered by infants in institutions. The infants Spitz has reported on were foundlings, or were living in a penal institution with their mothers. The starkness of their deprivations have made questions regarding the constitutional determinants of their maldevelopments seem irrelevant or impertinent. Yet when milder disturbances are observed among infants or young children living at home, the question of constitutional etiology is usually raised.

Surely a continuum from "worst" to "best" exists in conditions in institutional settings as well as in family homes. In view of this fact, one wonders why Spitz so often idealizes the usual mother-infant relationship. For example: "From the moment the mother comes into the room to the end of nursing [the infant] stares at his mother's face."

Numerous observers have been perplexed by this repeated statement since it is at odds with their own observations. Running films of over 110 infants fed by their mothers through the first year of life[9] have shown that most babies, breast fed, bottle fed, or even cup fed, rarely look at the mother's face (or are helped to do so) before, during, or after feedings.

A place in history

Wherever Spitz has relied upon direct observation and clinical understanding for his conclusions or new hypotheses, his work has achieved great distinction. The "psychotoxic disturbances" (rocking, colic, eczema, fecal play), for example, which came to his notice through his work on anaclitic depression, will provide other investigators with ample hypotheses for further studies. It is therefore regrettable that wherever he has not taken time to differentiate between assumptions, hypotheses, and general conclusions, he loses his stimulative effect.

Nevertheless, Spitz is assured of a lasting place in the history of infant psychology. In a period when his contemporaries were concerned almost exclusively with reconstructions about infancy, he dared to look at real live babies, facing the danger that his observations might disprove basic psychoanalytic theories. He brought to attention the importance of the infant's emotional life and dependence upon the mother, without postulating either an adultomorphic structure, a simple reflexive one, or one in which the infant became the source of his own difficulties. He made the psychological life of the infant plausible.

In interpreting his findings, Spitz showed that infancy was far more complex than had thus far been implied; that the first year of life is long enough and complicated enough to afford oceans of investigation; and that within its span, cumulative experiences are more likely than single traumatic events to lead to lasting pathological reactions in the child.

The subjective nature of many parts of Spitz' presentations reflect his eagerness to arouse in others a comparable dedication to the emotional lives of infants, and may be accounted negligible as long as we keep in mind the central issues: that the stimulation and deprivation of the infant can have specific and cumulative effects upon his social attachments; and that the nature of these attachments may facilitate or preclude the realization of his biological potentials.

Except for the Pavlovians in the field, practically all investigators since Spitz in some way have had their work shaped by his. This is more of an achievement for a man than to have all of his statements proved true.

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. . . the most forgotten, neglected individual in our society today is the fetus. . . .

John D. Thompson, M.D., chairman, Department of Obstetrics and Gynecology, School of Medicine, Emory University, Atlanta, Ga.

HERE and THERE

Family planning

More than 1,000 persons met in Washington, D.C., for 2 days in May at the National Conference on Family Planning, sponsored by Planned Parenthood-World Population and Planned Parenthood of Metropolitan Washington. They represented 65 national organizations in the fields of health, welfare, education, religion, civil rights, labor, and industry—including Protestant, Catholic, and Jewish groups. Meeting in general sessions and in smaller panel sessions, they considered family planning services as a right which should be accessible to all and as a necessity to control the world's exploding population.

In the general sessions, two United States Senators—Joseph D. Tydings of Maryland and Ernest Gruening of Alaska—urged stepped-up Federal action to deal with what President Johnson has termed "humanity's greatest challenge . . . second only to the search for peace"; representatives of the Department of Health, Education, and Welfare—Under Secretary Wilbur J. Cohen and Chief of the Children's Bureau Katherine B. Oettinger—told of Federal activities to promote research in fertility control, the expansion of family planning services as a part of maternal and child health, and the training of professional persons to provide the services; Secretary of Agriculture Orville L. Freeman spoke of the countereffects of population pressure on efforts to raise the level of nutrition in the developing countries; and Alonzo S. Yerby, M.D., New York City Commissioner of Hospitals, described the development of a network of family planning services for low-income families through the city's public hospitals.

Other city family planning programs—provided through health departments, hospitals, or anti-poverty community action programs—were outlined in some of the 11 panel sessions. As described, the programs were alike in stressing availability to the poor and insistence on the patient's right to choose which method of family planning, if any, she will employ; but they differed in whether or not they made efforts to "reach out" to persons considered to be in need of the services or to follow up on those served, and the availability or unavailability of their services to unmarried women.

There seemed to be a consensus that family limitation is no longer a controversial issue so long as freedom to choose is respected; but that there may be a moral question in whether or not unwanted children should be brought into the world. Some uneasiness was expressed, however, as to the effect of the availability of "the pill" on the sexual behavior of young people.

Pointing out that "a child has a moral and legal claim to be legitimate," a Catholic priest said he could not see how the social harms would be increased by permitting contraceptive counseling to a person who has already made a decision to enter upon an illicit relationship, that in his eyes the relationship and not the contraception was the evil. Another participant posed the question of how to engage in an effective education program about contraception for those young persons who are already engaged in sexual relations, "without stimulating or disturbing those who ought not to be reached."

There were warnings against the dangers of coercion in a family planning program focused chiefly on the poor. A priest pointed out, "We forget that the poor can also communicate human values and ideals." And a demographer, maintaining that the recent population explosion in this country was largely due to "over-wanting" on the part of couples who do control their family size, suggested an educational program to change the image of the ideal middle class family to one of only two or three children.

The chief accent in the conference was, however, on the poor and the effects of the combination of poverty and high fertility on family disorganization. George N. Lindsay, chairman of Planned Parenthood-World Population, reported a research-based estimate that 5 million fertile impoverished American women who want medical instruction in family planning are not receiving it.

The conference produced no formal recommendations, but reports from the panel groups accented the following needs: greater financial support for services, training, and research, especially from the Federal Government; more opportunities in medical schools for clinical practice in fertility control; more attention to rural areas; widespread educational programs about the availability of family planning; the inclusion of the concept of family planning in family life education programs in the schools; and increased aid to foreign countries in establishing family planning services.

. . .

On August 8, the 87-year-old legal ban against the dissemination of information about contraceptives and birth control will be lifted in Massachusetts, the last of 11 States to have had such a law in effect. Under a new law, passed in May, physicians will be permitted to prescribe contraceptives to married persons and public health and welfare agencies to furnish information on where contraceptives can be lawfully obtained. The new law, however, does not apply to unmarried persons.

Public assistance

New requirements to protect the dignity and rights to privacy of persons receiving or applying for public assistance, by respecting their constitutional and statutory rights, were issued by the Bureau of Family Services, Welfare Administration, in March 1966,

and will become effective July 1, 1967. Under these requirements, in order to receive Federal financial participation in their public assistance programs, States must show in their 1967 public assistance plans that prompt action will be taken on assistance applications, that "applicants and recipients will be relied upon as the primary source of information about their eligibility," and that "verification of conditions of eligibility will be limited to what is reasonably necessary to assure that expenditures under the program will be legal."

The interpretation accompanying the new requirements pointed out the need for States to "guard against violations in such areas as entering a home by force, or without permission, or under false pretenses, making home visits outside of working hours, and particularly making such visits during sleeping hours: and searching in the home, for example, in rooms, closets, drawers, or papers, to seek clues to possible deception."

The requirements were issued under the provisions in the Social Security Act requiring State public assistance plans to provide methods of administration necessary for "proper and efficient operation" and to include "reasonable standards" for determining eligibility "consistent with the objectives" of the program.

Mid-Decade Conference

The nearly 550 participants at the Mid-Decade Conference on Children and Youth, held in Washington, D.C., on April 12–15, looked back and ahead in considering the welfare of the Nation's young. They looked back to the 1960 White House Conference on Children and Youth to see whether the recommendations made then had been carried out, and they looked forward toward a possible 1970 White House Conference to see what should be done between now and then to fulfill the promise of the 1960 Conference. The Conference was sponsored by the National Committee for Children and Youth, the National Council of State Committees for Children and Youth (representing 42 State and territorial committees), the Council of National Organizations for Children and Youth (representing 360 national voluntary agencies), and the Interdepartmental Committee on Children and Youth (representing 38 Federal agencies). The participants included many young people.

At the opening general session, Ruth Stout of the Kansas State Teachers Association maintained that the young are "still criticizing us for what they criticized us in 1960." Wilbur J. Cohen, Under Secretary of Health, Education, and Welfare, pointed out that public and voluntary agencies have a great opportunity to achieve "three parallel goals": maximum coverage of all programs serving children and young people; broad community support for and understanding of current programs as rapidly as possible; and the improvement and extension of programs in response to change.

Much of the work of the Conference was done in small discussion groups at which participants reported on local programs and discussed the direction they thought future action should take. Participants also divided for one session into small seminars on health, family life, education, the disadvantaged, delinquency, and other topics relating to the welfare of the young.

Some participants reported that communication between groups and agencies working for the young was poor. Others, however, cited examples of close work between groups at all levels. Many maintained that programs were concentrating on economically deprived children to the exclusion of "deprived" children from affluent homes. They recommended setting up projects of interest to all young people. Many suggested that young people be brought into projects not just as representatives of youth but as active participants.

At the closing general session, Catharine V. Richards of the Children's Bureau, in summarizing the findings of the discussion groups, identified the following areas as needing action:

- *Family life*—Because it is an indispensable condition to meeting the child's right to basic subsistence, every family should have an income equal to its needs. Public welfare allotments should be increased to meet current cost of living. Efforts should be made to improve the life of parents as individuals. Ways must be found to let them know what services are available to them without making them feel incompetent if they use them. Children should have sex education and preparation for marriage and family life. There should be more services for unwed parents and for children born out of wedlock.
- *Health*—The gaps should be closed between the need for and the provision of prenatal care, well-baby clinics, and preventive medical care for children and young people. Efforts to control narcotics, alcohol, tobacco, and automobile accidents must be intensified. The public must be made aware of the need for better nutrition for *all* children.
- *Social services*—Better resources are needed for identifying potential dropouts at an early age. We must provide more day care, nursery schools, group homes for adolescents, and well-planned correctional programs. Programs for emotionally disturbed children should include integrated services for the prevention and treatment of their condition close to home.
- *Education*—Education should include preparation for work, experience in solving problems, and help in learning to live with others. Every child should have an opportunity for as much education as he can master; training in a skill should be open to those who do not go to college. Provision should be made for continuing education.
- *Research*—Research should be conducted on such subjects as the effects of urbanization on the family and the child and on the causes of such problems as births out of wedlock, student riots, violence, and juvenile delinquency.
- *Equal opportunities*—Every effort should be made to bring about equal opportunity for education, employment, and housing.

Mental retardation

Current knowledge and theories about the biochemical mechanisms involved in inborn errors of metabolism and the treatment of children having such defects were discussed at a 3-day conference on phenylketonuria and allied metabolic diseases, held in Arlington, Va., in April, under the auspices of the Children's Bureau and the University of Minnesota Department of Pediatrics. Participants were 65 scientific authorities in the fields of metabolism, medical care, and public health.

Major attention was focused on phenylketonuria (PKU), a disease characterized by high levels of phenylalanine in the blood which often results, when untreated, in mental re-

tardation. Speakers and discussants suggested a number of areas in which research is needed to track down the still elusive mechanisms in this disorder which cause mental retardation—for example, studies of the pharmacological effects of the metabolites, such as phenylethylamine.

Some controversy emerged in discussions of the widespread use of a low phenylalanine diet in treating the disease. Several participants reported clinical evidence of increased intellectual acumen in children given the diet for PKU; others questioned the assumption of the diet's beneficial effects on evidence not derived from controlled studies. The possibility of the development of protein deficiency, with adverse results, if phenylalanine levels in the blood became too low was also raised.

Other differences of opinion emerged in discussions of State laws requiring the testing of all children for PKU and other metabolic disorders. While some participants advocated such laws for their casefinding value, others maintained that they would hamper efforts to find improved treatment methods.

The full proceedings of the conference will be published by the Children's Bureau soon.

Mental health

A 2-year study of the mental health of children is being undertaken by the Joint Commission on Mental Health of Children, recently organized by the cooperative action of 13 professional and scientific organizations in response to the 1965 amendment to the Social Security Act which authorizes Federal expenditure for studies of emotional illness in children (Public Law 88–97). In May, the National Institute of Mental Health awarded the commission $500,000, effective June 1, 1966, for the first year of its study, the maximum that could be awarded under the law. The study will be carried on by task forces drawn from participating professional organizations and through contract with university research centers and similar institutions.

The purpose of the commission is to study all aspects of the problems of mental health in children and to formulate comprehensive plans and programs for dealing with these problems. A nonprofit, voluntary organization, it was organized by the American Psychiatric Association, the American Academy of Child Psychiatry, the American Academy of General Practice, the American Academy of Pediatrics, the American Association on Mental Deficiency, the American Association of Psychiatric Clinics for Children, the American Medical Association, the American Orthopsychiatric Association, the American Psychological Association, the National Association for Mental Health, the National Association for Retarded Children, the National Association of Social Workers, and the National Education Association.

The commission's board of directors includes 40 members, some representing the organizing societies and others chosen by the executive committee as persons with special competence.

In addition, there are eight liaison representatives from Federal agencies. Joseph M. Bobbitt is the commission's executive director. Its headquarters are in Chevy Chase, Md.

Child abuse

Many of the families of children reported as abused to the New York City Department of Welfare have deeply rooted social or personal problems, according to a study recently completed by the Columbia University School of Public Health and Administrative Medicine, under a grant from the Children's Bureau.

Begun in May 1965, the study was conducted by two public health physicians, Betty Simons and Elinor F. Downs. Its purpose was to inquire into the effectiveness of the State's new law (passed in 1964) requiring the reporting by physicians, and other health personnel, of suspected or confirmed child abuse and to obtain information about the epidemiologic and demographic facts of child abuse in New York City. It was conducted through interviews with staff members of social agencies and the review of information extracted from the Central Registry of Child Abuse, set up by the New York City welfare department's bureau of child welfare in 1964 to record cases reported under the law. This material was supplemented by case records made available by the department of welfare and the several voluntary agencies providing protective services in the city.

The investigators found that during the first year the law was in effect, 313 cases of suspected child abuse in 293 families had been reported. Two-thirds of the children were under 5 years of age; one-third had histories of past abuse. Patterns of abuse ranged widely and did not lend themselves to "pat definitions and categorizations," according to the investigators. The families represented a wide variety of cultural backgrounds and the child abuse among them a complex of symptoms including in many instances mental illness.

. . .

As a result of 1966 legislative sessions, Mississippi, Virginia, and the Virgin Islands now have laws requiring physicians to report suspected cases of child abuse; and Maryland amended its law which, among other changes, provides for a central registry on child abuse.

In Mississippi and Virginia reports of suspected abuse are to be made to youth courts and juvenile courts, respectively. Maryland's new law requires reports to be made to local welfare departments.

Hawaii is now the only State without a child abuse reporting law. Other jurisdictions without such laws are Puerto Rico and the District of Columbia. In the District of Columbia, pending legislation, passed with differences by the U.S. Senate and by the House, is awaiting action of a conference committee.

Manpower needs

Nearly 100,000 additional social workers with graduate degrees will be needed by 1970 by public and voluntary welfare, health, and educational agencies to carry out programs in which the Department of Health, Education, and Welfare has a direct concern, according to the findings of a 3-year study conducted by a special Departmental task force.

This figure was based on estimated needs for additional professionally trained social workers in the following programs: public assistance programs, 31,500 more; public child welfare services, 10,000 more; schools, 17,000 more; juvenile delinquency treatment programs, 11,500 more; community mental health programs and mental hospitals, 10,500 more; hospitals, clinics, and other health facilities, 12,000 more; and services for the aging, 3,200 more.

In addition, the task force reported, most of these programs will need more

college graduates who have had undergraduate courses in social work and more high school graduates with vocational training qualifying them for ancillary tasks.

Pointing out that even these estimates do not take into account the effects of the 1965 amendments to the Social Security Act, the task force has recommended:

- The expansion of graduate and undergraduate training facilities and of programs of financial aid to students, including scholarships.
- The development of a special undergraduate curriculum to prepare the students for direct entry into social agencies after receiving a bachelor's degree—to be followed by on-the-job training.
- The establishment of regional recruiting committees, with paid staffs, to encourage young people to enter the field of social work.
- The adoption of better salary scales and the provision of career opportunities.
- The establishment of a center for the continuous receipt and analysis of data on social work manpower needs.

The report of the study, "Closing the Gaps in Social Work Manpower," is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, for 55 cents a copy.

Child welfare research

Thirty-six specialists in child care attended a 3-day workshop on group residential care of infants and young children, held in New Haven, Conn., March 31–April 2, 1966, under the sponsorship of the Children's Bureau and the Yale Child Study Center. The workshop was called as part of a Children's Bureau effort to encourage a re-examination through objective research of some of the issues concerning the group care of infants and young children. Participants represented the disciplines of social work, child development, psychology, education, psychiatry, pediatrics, and public administration.

Among the participants was Anna Freud, director of the Hampstead Clinic, London, who described some of her experiences with the group care of children evacuated from London during World War II. She expressed approval of the efforts in this country to re-examine the issues of group care, but recommended that more attention be given to the values and use of foster family care and special day-care programs. She also raised questions about the "current preoccupation" here with the cognitive development of children, to the disregard of their needs as a whole.

Other participants presented papers on the developmental needs of the infant and preschool child, existing programs of group care of young children, problems of staffing for group care, planning the daily experience of the child, planning the physical environment, the residential facility and the community, and health needs of young children in group care. In the ensuing discussions, participants blamed much of the limitations in current child welfare services on the lack of insufficient funds and staff, but they also maintained that the adequacy of services was limited by a failure to develop modes of foster care based on current knowledge and theory in the fields of child development, psychology, and learning.

The proceedings of the workshop, which was under the chairmanship of Sally Provence, M.D., of the Yale Child Study Center, are to be published by the Children's Bureau.

. . .

A new research project on cost analysis in children's institutions was initiated last February under the auspices of the American University School of Government, Washington, D.C., with a 3-year grant from the Children's Bureau. The project, which is under the direction of Robert Elkin, has four objectives: (1) to produce a simplified cost procedure for children's institutions for widespread annual administration using local resources; (2) to analyze the time and cost data produced in about 60 institutions using a manual on cost analysis developed by the Child Welfare League of America; (3) to experiment with developing a classification system for institutions which will identify different levels and sizes of program operation; and (4) to study the feasibility of developing a model for or system of cost-benefit analysis in children's institutions.

The new project will build on the results of study completed last spring, also directed by Mr. Elkin, by the Child Welfare League of America and the Children's Bureau, with a grant from the Field Foundation. One of the principal findings of the earlier study is that the system of cost analysis must be simple enough to attain widespread annual usage and at the same time useful as a base for building a more complex system for institutions which need to analyze complicated cost issues. The study also found that the issues of technical consultation and training must be considered thoroughly; and that personnel trained to administer a cost analysis system are crucial to success.

. . .

Sheldon and Eleanor Glueck of the Harvard Law School are cooperating in a project in Puerto Rico which employs some of the procedures used in their research on characteristics of juvenile delinquents, first reported in their book "Unraveling Juvenile Delinquency" (Harvard University Press for the Commonwealth Fund, Cambridge, Mass., 1950). Some of the same tests and inventories that were used in their earlier study are being administered in the Puerto Rico project to 300 delinquent and 300 nondelinquent youths matched on the basis of age and cultural background. Included also are several additional measures, such as skull X-ray and electroencephalograph records, and several newer projective tests.

The purpose of the project is to identify causal factors in juvenile delinquency.

The project is being financed by the University of Puerto Rico, the Government of Puerto Rico, and the U.S. Office of Education.

Health care

By June 1, health agencies in nine cities and one rural area had received grants to set up comprehensive health services for children and young people living in neighborhoods with many low-income families. In addition to the Chicago Board of Health (see CHILDREN, May–June 1966, p. 123), the awards have been made to—

- Beth Israel Hospital, Boston, $224,000, for a project to serve children and young people in Roxbury, Mass., at the hospital, a clinic in Roxbury, and in their homes.
- Minneapolis Health Department, Bureau of Maternal and Child Health,

$1,049,440, to work through the Hennepin County General Hospital, child clinics in the city, work service centers for high school students, the University of Minnesota hospitals, and other agencies.

• Ohio State Department of Health, Columbus, Ohio, $1,089,671, to set up a "3 C's" program (Comprehensive Care Clinic of Columbus Children's Hospital), at the Columbus Children's Hospital. The project will serve children and young people in Columbus, Franklin County, and several other counties in southeastern Ohio.

• Children's Mercy Hospital, an affiliate of the University of Missouri School of Medicine, Kansas City, Mo., $939,514, to cover a low-income city area including about 51,000 families.

• New York City Department of Health, $413,535, to operate the Rockaway Health Center of the Queens Hospital Center for children and young people living in the Rockaway Peninsula (an area geographically isolated from the rest of the city).

• New York University Medical Center, $1,589,738, to cover the area served by Bellevue Hospital. The project will include a Medical Records-Information Retrieval Center for *all* children served by Bellevue to record medical and social information for the use of Bellevue and other institutions.

• Johns Hopkins Medical Institutions, Baltimore, Md., $1,252,555, to serve children and young people in a 2½-mile radius of the Johns Hopkins Hospital.

• Baltimore City Health Department, Baltimore, Md., $2,066,125, to serve children and young people in the inner city through two teaching hospitals—the University of Maryland and the Sinai Hospital. The Presbyterian and the Baltimore City Hospitals are to be included as the project develops.

• Children's Hospital of Philadelphia, $443,950, to cover an area of south Philadelphia adjacent to the hospital.

• State Services for Crippled Children, University of Iowa, Iowa City, Iowa, $340,308, to serve children and young people in the rural areas of Clarke, Lucas, Decatur, and Wayne counties through multi-purpose centers in each county.

All projects will cooperate with other public and private health agencies in the community; public and parochial school systems; university medical schools and hospitals; and local, State, and Federal welfare agencies including Project Head Start. The projects will also include informational programs for parents to encourage them to use the centers.

. . .

With the initiation of a program in Ohio this spring, all 50 States, the District of Columbia, and Puerto Rico are now conducting health referral and counseling programs for young men rejected by the Armed Forces for medical reasons. Under the program, which is sponsored by the Public Health Service in collaboration with the Vocational Rehabilitation Service, designated State agencies have received contracts from PHS for services—offered at Armed Forces examination stations—to advise rejectees on their health problems and to refer them to health and rehabilitation facilities in their own communities. Follow-through by the rejectee is entirely voluntary.

The program has served more than 151,000 young men since it began in 1962, with pilot projects in New York City and Philadelphia, on the recommendation of a subcommittee on community services for Selective Service registrants of the Interdepartmental Committee on Children and Youth. (See CHILDREN, January–February 1962, p. 35.)

Unmarried parenthood

Attitudes toward unmarried parenthood differ, sometimes greatly, among unwed mothers, their parents, and professionals who serve them, according to the findings of a project recently completed by the Research Center of the Columbia University School of Social Work. The project, directed by Deborah Shapiro, was initiated by the Salvation Army, Eastern Territory, and supported by a grant from the Children's Bureau. It involved the questioning of 134 unwed mothers, 65 of their parents, and 100 staff members of two Salvation Army hospitals in New York City and Cincinnati, Ohio. Respondents were asked to rate their attitudes on a scale, going from strong acceptance on the one hand to strong rejection on the other, toward statements regarding the morality, responsibility, and underlying values related to unmarried motherhood.

Only 29 percent of the unmarried mothers among the respondents were 20 years old or older. About 35 percent were still in high school. Sixty-seven percent were white; all others were Negro. Among the white mothers, 61 percent were classified as from upper lower class families, 25 percent from middle class families, and 14 percent from "unstable" lower class families. Among unwed Negro mothers, all but four were classified as from "lower class families." Of the staff members, 38 percent were classified as middle class professional men and women or middle class white-collar workers; the others were classified as lower class semiskilled or unskilled workers.

The project found that the respondent's role—unwed mother, parent, or staff member—seems to have more bearing on his attitude than differences in race and social class. The greatest difference in attitude was noted between the unwed mothers and hospital staff members, although the difference between unwed mothers and their parents was almost as great. Middle class unwed white mothers differed from both parents and staff members. Lower class unwed Negro mothers differed most from staff members, less from their parents. Lower class unwed white mothers agreed with both parents and staff members almost as often as they disagreed.

The majority of respondents in all groups said they believed all sexual behavior should be confined to marriage.

The project concluded that the widespread assumption that Negroes accept illegitimacy more readily than whites is only "relatively true," that although lower class unwed Negro mothers are more likely to respond in a way which suggests mixed feelings than lower class unwed white mothers, both groups have ambiguous sexual mores.

The project also found indications that staff members of the participating agencies gave their clients appropriate immediate service, but were likely to be hampered by the social distance between client and staff in reaching long-term and more complex goals.

In all three samples Negro respondents more frequently than white respondents said they would prefer keeping a child born out of wedlock rather than placing him for adoption.

BOOK NOTES

THE MATURATIONAL PROCESSES AND THE FACILITATING ENVIRONMENT: studies in the theory of emotional development. D. W. Winnicott. International Universities Press, New York. 1965. 295 pp. $6.75.

This book is a collection of papers on psychoanalysis and child development prepared between 1957 and 1963 when the author was a physician at Paddington Green Children's Hospital in England. Stating his theme as "the carrying back of the application of Freud's theories to infancy," the author stresses the role of dependence in healthy or pathological personality growth.

The papers focus on some of the processes in achieving specific goals of child development—including the capacity to be alone, the capacity for concern, independence, and moral values—and on the contributions of various theories to the techniques of treating antisocial, mentally ill, or neurotic children and adolescents.

TEACHING THE CULTURALLY DISADVANTAGED PUPIL. Compiled and edited by John M. Beck and Richard W. Saxe. Introduction by Robert J. Havighurst. Charles C Thomas, Springfield, Ill. 1965. 335 pp. $10.50.

The 16 essays in this book, by college instructors, educational researchers, and elementary school administrators, discuss the problems of the culturally disadvantaged pupil and what can be done through education to help him break out of the cycle of poverty. They are grouped under three general headings: basic characteristics of the disadvantaged pupil; the disadvantaged pupil in the elementary school; and the school and community and the disadvantaged pupil.

In the introduction, Dr. Havighurst maintains that we have enough research on disadvantaged children to show that emphasis should be placed on preschool and elementary school experiences.

The essays in the first section draw upon research in anthropology, sociology, and psychology in analyzing the problems of the culturally disadvantaged pupil and the instructional programs that can help him. In one, the author, William E. Gorman, points out that a distinction must be made between the culturally different child—who may not be disadvantaged—and the culturally disadvantaged.

The essays in the second section, by subject-matter specialists, describe teaching procedures which have proved successful in working with disadvantaged pupils in various subjects.

Essays in the third section discuss the preparation of teachers and the major responsibilities of school administrators and communities for the education of disadvantaged pupils.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume XX. Ruth S. Eissler, Anna Freud, Heinz Hartmann, and Marianne Kris, editors. International Universities Press, New York. 1965. 566 pp. $10.

This 20th volume in an annual series contains 25 contributions grouped under 4 major sections: diagnostic assessments (chiefly concerned with discussions of Anna Freud's "diagnostic profile"), aspects of normal and pathological development, contributions to psychoanalytic theory, and clinical contributions.

Three reports are included on research with blind children. Doris M. Wills reports that the blind nursery school children she observed seemed to have their own way of thinking. She suggests that the blind child may have to be helped to think in his own way before being taught how to adapt to the world of the seeing.

Dorothy Burlingham describes the problems of motor restraint, verbalization, and object recognition in blind children. She disagrees with the widespread belief that blind children have unusual acoustic and tactile ability. ". . . what blind children really possess to an extraordinary degree," she says, "is an excellent memory made more and more efficient by constant inward looking."

Humberto Nagera and Alice B. Colonna cite evidence suggesting that ego development in children blind from birth is retarded by lack of necessary visual contributions as well as by attitudes toward the blind.

Among other articles are papers on early male adolescence, inhibition of aggression in infancy, and impaired ego development in children with physical malformations.

WILDERNESS ROAD. Campbell Loughmiller. Hogg Foundation for Mental Health, University of Texas, Austin. 1965. 139 pp. $2.50.

This book describes the program of a 24-hour, year-round camp for treating moderately disturbed boys.

In contrast to most residential treatment centers which provide treatment, daily program, food and lodging *for* the patient, Camp Woodland Springs, sponsored by a Dallas service club, requires the boy and his parents or parent to engage themselves in a treatment-planning conference with the institution's caseworker, administrator, counselors, and others, according to the author. He tells how the boy and his unit group of nine develop their own daily and weekly program in collaboration with two adult counselors; and how they build their own rustic shelter, cut wood for fuel, cook half their meals, and review their day's accomplishments in regular evening group discussion.

Education and rehabilitation through daily accomplishment, self-involvement, and relationship with supportive adults and buddies form the core of the treatment program described. The staff makes creative use of daily experiences at home and in trips through nearby States in helping the boys deal with their emotional problems.

HEALTH AND THE COMMUNITY: readings in the philosophy and sciences of public health. Edited by Alfred H. Katz and Jean Spencer Felton. The Free Press, New York. 1965. 877 pp. $12.50.

The 76 papers in this book on aspects of health and the community have been selected from a variety of professional

journals and other publications as representing a broad view of practice and research that, according to the editors, admits of "the possibility of obsolescence and change" while retaining "basic attitudes, values, and goals."

They are classified under eight general subjects: changing social conditions and health needs; the people served; arenas of health service; the sciences and disciplines of public health; changing emphasis in public health; innovations and adaptations; special studies; and goals and priorities in a changing world. Included are papers on deaths associated with childbirth; prenatal factors in the production of neuropsychiatric disorders; mental retardation; job opportunities and youth; teenagers and venereal disease; school health programs; malnutrition and child health; and public health dental programs.

MODES OF THINKING IN YOUNG CHILDREN: a study of the creativity-intelligence distinction. Michael A. Wallach and Nathan Kogan. Holt, Rinehart and Winston, New York. 1965. 357 pp. $8.

This is a report of a rigorous investigation of "the ability called creativity." The authors are psychologists: Dr. Wallach, at Duke University; Dr. Kogan, at the Educational Testing Service. They set out (1) to determine whether they could find sound evidence to support their assumption that creativity and intelligence are distinct modes of thinking and (2) to find the possible psychological correlates of individual differences in creativity and intelligence when variations in both are considered at the same time. As a result of their investigation, they conclude that creativity and intelligence are separate and that permissive conditions are necessary if creativity is to flourish.

The investigation involved 70 boys and 81 girls, 10 and 11 years old, in the fifth grade of a public school in a New England town. All were from middle-class families. The study took nearly 7 weeks, including 2 weeks of observation only. Tests of various kinds were given under play conditions, always without a time limit.

The children fell into four groups: intelligent and creative, intelligent and not creative, creative but not intelligent, and neither creative nor intelligent. The intelligent but not creative children seem to be making out the best in school. The creative but not intelligent children seem to be having the most difficulty and were often disruptive in the classroom. Differences also existed between boys and girls in the same groups.

The book includes chapters on behavior, categorizing and conceptualizing, sensitivity to physiognomic properties, the role of anxiety and defensiveness, and studies of individual children. In the concluding chapters, the authors discuss the implications of their findings for education.

SOCIAL WORK PRACTICE, 1965: selected papers, 92d annual forum of the National Conference on Social Welfare, Atlantic City, New Jersey, May 23–28, 1965. Columbia University Press, New York, for the National Conference on Social Welfare. 1965. 253 pp. $6.

The 17 papers in this book were selected from the papers on casework, group work, community organization, and social action presented at the 92d annual forum of the National Conference on Social Welfare.

in the journals

Parent education

In the April 1966 issue of *Nursing Outlook*, Edith L. Amend describes the parent education program at Children's Hospital of Philadelphia, of which she is the coordinator. ("A Parent Education Program in a Children's Hospital.")

Four parts of the hospital's program, she maintains, have insured good hospital-parent relationships: (1) conferences with parents before a child's surgery; (2) instruction for parents of myelomeningocele patients, infants who must remain in the hospital, and diabetic children; (3) unlimited visiting hours; and (4) a teaching program for the nursing staff.

"Because the ultimate care of the child rests with parents," she points out, "great efforts must be made to strengthen family relationships during hospitalization." At the same time, she says, it is important "to coordinate the hospital's efforts to insure parents that their child will receive good care, and that there will be continuity of this care when they take him home."

Smoking and birth weight

A study of more than 2,500 mothers in Baltimore, Md., who smoked or did not smoke during pregnancy, described in the April 1966 issue of the *American Journal of Public Health*, by James R. Abernathy, Bernard G. Greenberg, Bradley Wells, and Todd M. Frazier, confirmed the results of an earlier study of these mothers by Mr. Frazier and others. ("Smoking As an Independent Variable in a Multiple Regression Analysis Upon Birth Weight and Gestation.") Both studies found that babies born to mothers who smoke tend to be smaller than babies born to nonsmoking mothers though there is little difference in the gestation periods.

The authors maintain that the agreement between the findings of their two studies is "singularly important" because their present analysis was conducted with "due consideration of the multiple characteristics of the mother"—such as her smoking history and whether she had hypertension or eclampsia.

The authors suggest that one possible common characteristic in the smoking mothers may have been a reduced flow of blood across the placenta during pregnancy. Such a reduction, they maintain, if it existed, could have adversely affected the intrauterine growth of the fetus. When a satisfactory method of measuring the flow of blood

across the placenta is found, it will be possible to study the effect of smoking on the flow of blood, the authors conclude.

Genetic counseling

Two articles in the April 1966 issue of *Social Work* discuss genetic counseling in social work. ("The Challenging Opportunity for Social Workers in Genetics," by Sylvia Schild of Children's Hospital, Los Angeles, and "The Impact of Genetic Disorders," by Amelia L. Schultz, of the Clinical Research Center, University of Washington, Seattle, Wash.)

In the first, the author maintains that genetics counseling offers great opportunity for the application of casework services. Family planning and genetic counseling are not, she points out, synonymous. In genetic counseling, the social worker's job is to identify some of the psychosocial problems that genetic disorders can bring to a family and to help the family solve its problems, especially to help each member overcome the injury to the ego that discovery of a genetic disorder can bring to a person.

In the second, the author discusses many of the factors involved in the reaction of a family to the discovery that the parents carry genetic disorders. Although "it may be some time before many social workers are employed generally in genetic clinics," she maintains, families facing the problems genetic disorders bring do come to the attention of social agencies. The social worker can help them face the threat to life or social functioning, accept the reaction of other people, and work out ways of meeting the financial strain that may be imposed. "If social workers are aware of these possibilities," she concludes, "they may increase their sensitivity to genetic problems and their helpfulness to those who suffer from them."

readers' exchange

MALUCCIO: *More about support*

Agencies are familar with the stress-producing effects that emotionally disturbed children have on foster parents, so well described in Anthony Maluccio's article. ["Selecting Foster Parents for Disturbed Children," by Anthony N. Maluccio, CHILDREN, March–April 1966.]

Therefore, we must try to understand why this happens and what can be done to remedy the situation. Such understanding would have implications for methods by which we select foster parents, the process of matching children with foster parents, and the casework services provided for foster parents.

As Elizabeth A. Lawder has already pointed out elsewhere ["Toward a More Scientific Understanding of Foster Family Care," *Child Welfare*, February 1964], to effect a careful matching of a child with a foster-parent couple, we have to know more about the interests, motivations, and aspirations of the prospective foster parents than can be gleaned from the standard home study.

In the home study devised in the Merrifield Center, a project sponsored by the Worcester Children's Friend Society and the Worcester Youth Guidance Center with a grant from the National Institute of Mental Health, besides the usual criteria for selecting foster parents, the following criteria are considered essential in selecting foster parents for emotionally disturbed children: (1) sufficient comprehension of the temporary nature of placement to enable them to help the child maintain ties with his own family if advisable; (2) the ability to cooperate with the agency in closely shared responsibility; and (3) the ability to respond to a learning experience.

Recognizing the need such foster parents have for support, Merrifield Center (1) periodically conducts group-training program meetings for the foster parents; and (2) schedules weekly casework conferences with individual foster parents beginning when they are asked to consider a specific child and continuing as long as he is in their home.

Peter E. Reinhold
Project Executive, Merrifield Center, Worcester, Mass.

PAULSEN: *What is neglect?*

Monrad G. Paulsen has performed a valuable service in reviewing the general legal framework in which the problem of child protection is now being handled. ["Legal Protections Against Child Abuse," CHILDREN, March–April 1966.]

Mr. Paulsen makes an important point in stressing that protection of the children is the vital consideration rather than punishment of the parents. Unfortunately, there is considerable variation of opinion on what constitutes such protection.

Mr. Paulsen comments: "What a judge is likely to characterize as 'neglect' will, I believe, depend upon the action which he feels called upon to take." This would seem to leave the decision open in specific cases to the particular bias of the judge, and in practice this does happen. The definition of neglect is particularly vulnerable to subjective influence.

Mr. Paulsen seems wary of tackling the question of when permanent removal of a child from his natural home is necessary, and of the relation to this of the degree of abuse. Yet these questions must be faced if we are to protect children in fact as well as in theory.

While there can be no argument with Mr. Paulsen's advocacy of a "multidisciplinary network of protection . . . in each community," it should be pointed out that the effectiveness of any such network will depend on the willingness of its participants to study the realities of the problem and to plan according to those realities.

The law assumes that parents are in effect the advocates for their children. When this is so, there is no problem. When this is demonstrably not true, the question is: Who are the children's advocates?

Leontine R. Young
Executive Director, Child Service Association, Newark, N.J.

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MENTAL RETARDATION ACTIVITIES OF THE U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. Annual Report, January 1966. Department of Health, Education, and Welfare, Office of the Under Secretary, the Secretary's Committee on Mental Retardation. 1966. 87 pp. 50 cents.

Part I of this publication summarizes the various aspects of the Department's concern with mental retardation and the recent Federal legislation under which its mental retardation programs are operated. Part II describes the specific mental retardation programs of nine HEW agencies. Appendices present information on Federal authorizations and expenditures for fiscal years 1965 and 1966 by type of activity and administrative agency.

GRANTS FOR COMPREHENSIVE HEALTH SERVICES FOR CHILDREN AND YOUTH—POLICIES AND PROCEDURES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 27 pp. Single copies free on request from the Bureau.

An outline of the procedural requirements and staffing standards established by the Children's Bureau for the special projects to provide comprehensive health care for preschool and school-age children in low-income areas authorized under a 1965 amendment to title V of the Social Security Act.

SERVICES FOR CHILDREN: how title V of the Social Security Act benefits children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 17 pp. Single copies free on request from the Bureau.

Answers 24 questions about the nature and purpose of the grant programs administered by the Children's Bureau.

THE PRACTICE OF NURSE-MIDWIFERY IN THE UNITED STATES. Margaret W. Thomas. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 436. 1965. 61 pp. 25 cents.

Reports on a study of the extent and nature of nurse-midwifery practice in the United States in 1963–64. (See CHILDREN, May–June 1965, pp. 122–123.) Also includes a substudy describing the attitudes of physicians toward nurse-midwifery.

YOU CAN QUIT SMOKING. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 433. 1965. 19 pp. 15 cents.

Addressed to teenagers who want to stop smoking, this pamphlet offers suggestions to help young people hold to their decision to stay away from cigarettes. The guidelines offered are based on the experiences of many teenagers who, after making the decision to stop smoking, succeeded in giving up cigarettes.

BREAST FEEDING YOUR BABY. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 8, 1965. 27 pp. 10 cents.

This booklet offers suggestions for the mother's diet while breast feeding her baby, for care of her breasts, and for weaning. It also points out that breast feeding can be an enjoyable and comfortable, emotionally supportive experience for both mother and infant.

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Page 133, Morton R. Engelberg, for Project Head Start.
Page 147, Luigi Pellettieri, New York University.

CHILDREN is published by the Children's Bureau six times a year. Use of funds for printing this publication was approved by the Director of the Bureau of the Budget, September 21, 1962.

NOTE TO AUTHORS: Manuscripts are considered for publication only if they have not been previously published. Speeches from conferences should carry appropriate identification. Opinions of contributors not connected with the Children's Bureau are their own and do not necessarily reflect the views of CHILDREN or of the Children's Bureau.

Communications regarding editorial matters should be addressed to:

CHILDREN
Children's Bureau
U.S. Department of Health, Education, and Welfare,
Washington, D.C., 20201.

Subscribers should send payment directly to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

CHILDREN is regularly indexed by the Education Index and the Nursing Literature Index

UNITED STATES GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C., 20402, 1966

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402
Price 25 cents a copy. Annual subscription price $1.25. 50 cents additional for foreign subscriptions.

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AN INTERDISCIPLINARY JOURNAL FOR
THE PROFESSIONS SERVING CHILDREN

published 6 times annually by the

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of HEALTH,
EDUCATION,
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